Psychiatric Treatment in Child Welfare:
Best Practices and Causes for Concern

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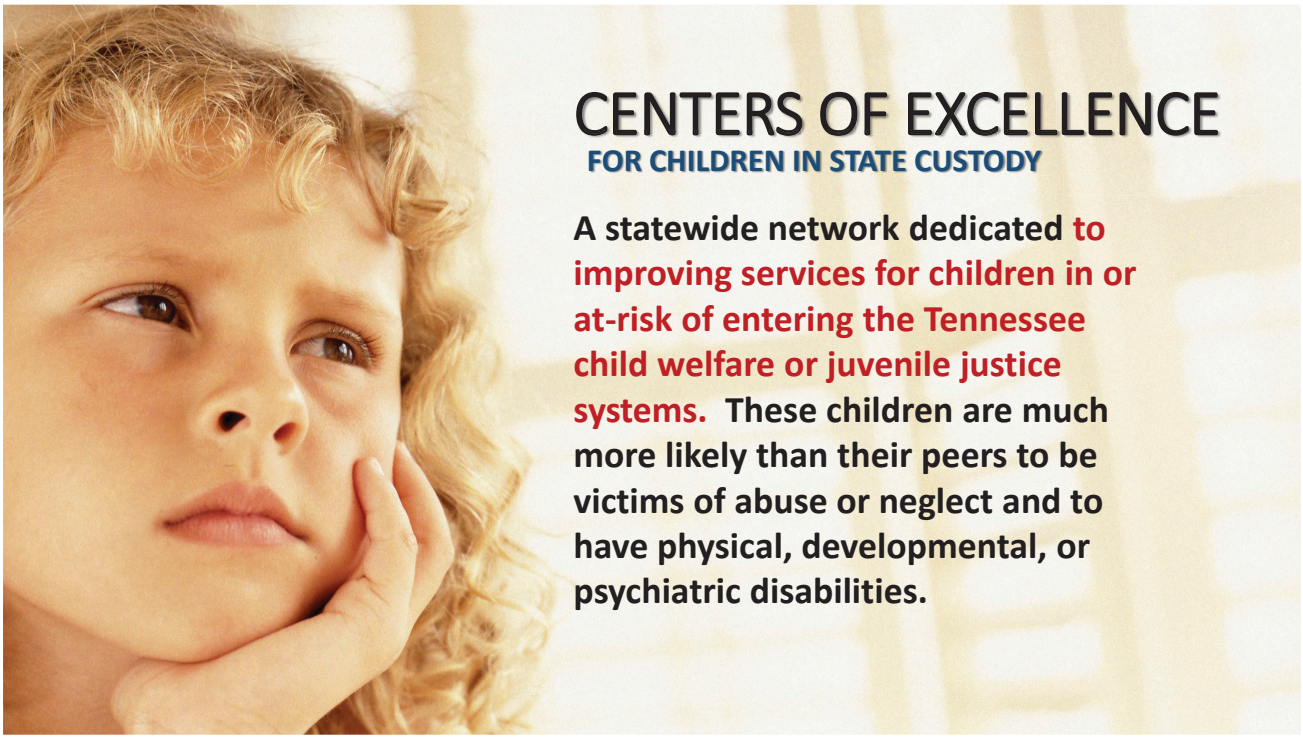

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Mental health and psychotropics in child welfare

What we know:

Youth in foster care have high rates of developmental, behavioral, and emotional needs.

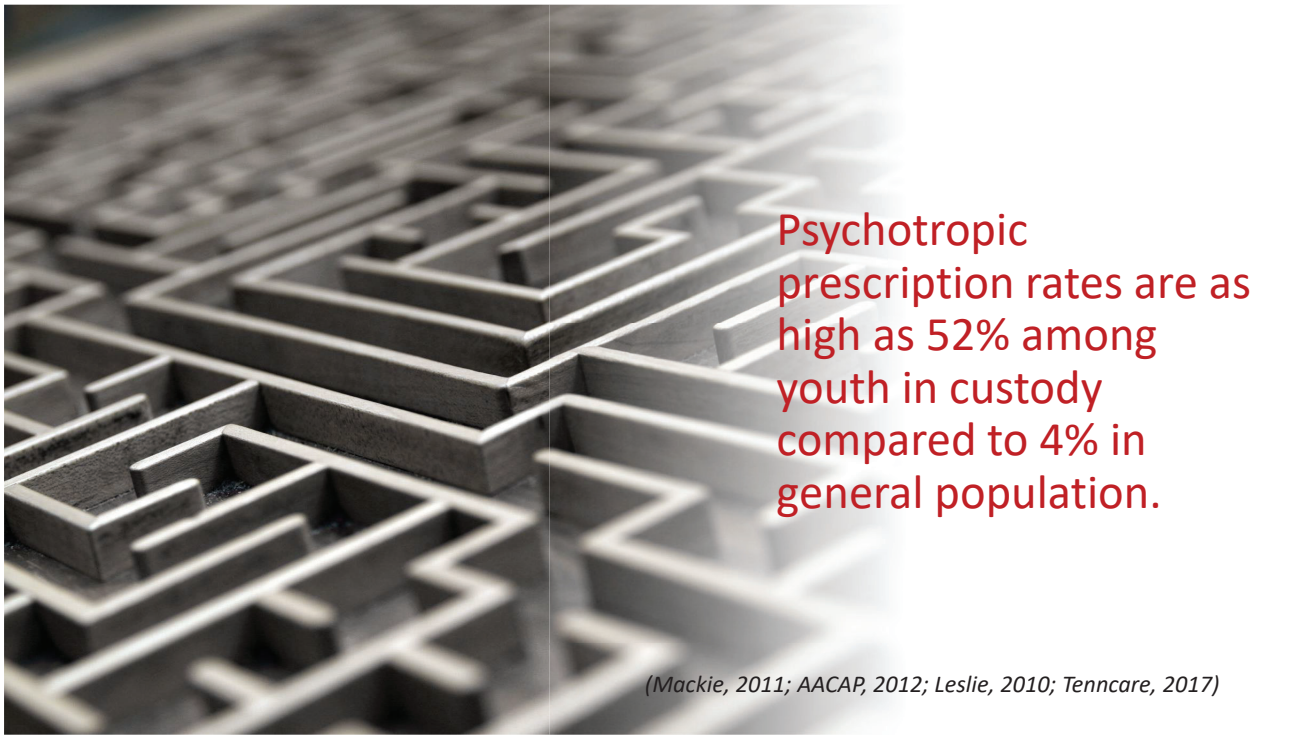
Compared to other Medicaid covered youth, those in child welfare have significantly greater mental health service use, expenditures, psychotropic mediation prescriptions.

National prescription rates of psychotropic medications in youth are rising dramatically.

This increase is even more pronounced in youth in child welfare systems.

- Higher for every age group
- Higher rates of polypharmacy

(Mackie, 2011; AACAP, 2012; Leslie, 2010; Tenncare, 2017)



Psychotropic prescription rates are as high as 52% among youth in custody compared to 4% in general population.

(Mackie, 2011; AACAP, 2012; Leslie, 2010; Tenncare, 2017)

TN 2017 Pharmacy Data

32% of youth in TN DCS custody were prescribed one or more psychotropic medications

19.4% of the children prescribed at least one drug were prescribed 4 or more medications for at least one month of the calendar year

WHY THIS MAY BE REASONABLE

- Appropriate reflection of higher rates of mental health disorders in the context of:
  - Emotional and physical consequences of developmental trauma
  - Prenatal exposures
  - Genetic vulnerability
- Benefit of the system
  - Access to treatment
  - Appropriate screening and assessments
  - Advocacy for indicated treatments

WHY THIS MAY BE CONCERNING

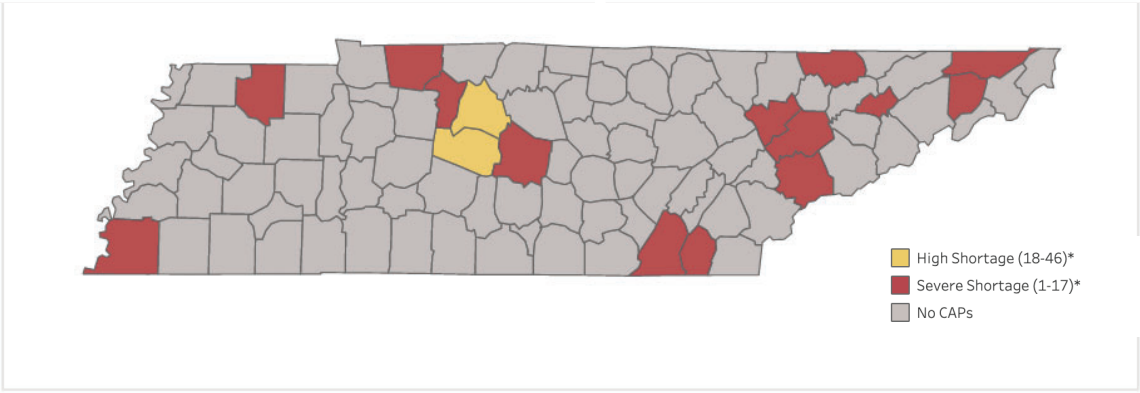
- Lack of effective oversight of medical treatment
- Inappropriate overreliance on meds vs non-pharmacologic interventions
- Insufficient time for clinicians to evaluate and reassess
- Insufficient information about history and current function
- Limited support for collaboration among providers and stakeholders
- Under-recognition of trauma etiology
- Unrealistic goal of stabilizing a complex psychosocial situation with medication

Who is prescribing?

- Child and Adolescent Psychiatrists
- General Psychiatrists
- Developmental and Behavioral Pediatricians
- General Pediatricians
- Pediatric Neurologists
- Advanced Practice Nurses

National shortage of CAPs limits access

Number of Children < 18	Total CAPs	Number of CAPs/100K	Avg. CAP Age
1,499,076	107	7	49



https://www.aacap.org/aacap/advocacy/federal_and_state_initiatives/workforce_maps/home.aspx

Best practices

Psychiatric treatment process includes multiple steps

- Evaluation
- Biopsychosocial Formulation
- Comprehensive Treatment Plan
- Psychoeducation
- Informed consent/assent
- Monitor progress

Phases of treatment

- Assessment
- Acute stabilization
- Maintenance
- Discontinuation

Informed consent

Parents retain medical decision-making rights unless otherwise ordered

When parental rights are terminated or parents cannot be located, DCS provides consent

Youth provides assent

Common disorders for youth in custody

- Developmental delay
- Depression
- Anxiety
- PTSD/ complex developmental trauma
- ADHD
- Learning Disabilities
- Substance use disorders

Common disorders for youth in custody

- Developmental delay
  - Failure to meet expected milestones
  - Tantrums
  - Speech and language impairment

Common disorders for youth in custody

Depression

- Low mood
- Loss of interest
- Irritability
- Poor concentration
- Appetite changes
- Sleep changes
- Negative “automatic” thoughts
- Hopelessness
- Guilt
- Worthlessness
- Thoughts about suicide

Common disorders for youth in custody

Anxiety

- Separation
  - Fears about loss of attachment figure
  - Difficulty being away from caregiver
  - Difficulty sleeping alone
- Social
  - Speaking in front of others
  - Meeting new people
  - Asking for help
- Generalized
  - Uncontrollable worries

Common disorders for youth in custody

ADHD

- Inattention
- Hyperactivity/Impulsivity
- Occurs in more than one context

- Medication is first line treatment

Common disorders for youth in custody

Substance use disorders

- Unable to control use
- Cravings
- Tolerance/withdrawal

- Screening:
- Car
- Relax
- Alone
- Friends/Family
- Forget
- Trouble


Developmental trauma is the great masquerader. Trauma responses may mimic almost any other diagnosis.


Youth in child welfare are at greater risk for suicidal thoughts, suicidal behaviors, and non-suicidal self injury

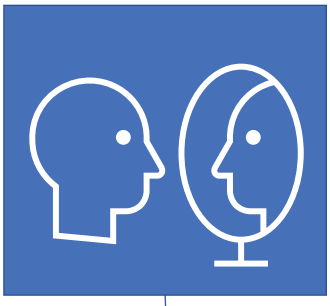
TALKING ABOUT SUICIDE...

- **Suicide:** death caused by self-injurious behavior with any intent to die
- **Suicidal ideation:** thoughts of suicide
  - Passive SI
  - Active SI
- **Suicide attempt:** engaging in self-harm with any intent to die
  - Suicidal behavior
- **Non-suicidal self-injury:** engaging in self-harm without intention to die
- **Self-injurious thoughts and behaviors**

TALKING ABOUT SUICIDE...

Instead of…	Use…
Commit/committed suicide	Died by suicide, death by suicide, lost their life to suicide
Successful/unsuccessful suicide	Died by suicide, survived a suicide attempt, lived through a suicide attempt
Completed/failed suicide	Fatal suicidal behavior / non-fatal suicidal behavior
Suicidal person	Person is experiencing suicidal thoughts / thinking of suicide / has experienced suicidal thoughts / engaged in suicidal behavior

Causes for concern



Biopsychosocial Formulation

EVIDENCE BASED INTERVENTIONS

- TF-CBT -- Trauma Focused Cognitive Behavioral Therapy
- ARC -- Attachment Regulation and Competence
- DBT -- Dialectical Behavior Therapy for Adolescents
- CPP -- Child Parent Psychotherapy
- PCIT -- Parent Child Interaction Therapy
- Combined Parent-Child CBT
- Resource Parent Curriculum
- Child Welfare Trauma Training Toolkit
- Child-Adult Relationship Enhancement (CARE)

not an exhaustive list

Prescribing Red Flags

Too many
Too much
Too young

- Prescribing for young children (<6 years)
- Prescribing multiple concurrent medications (>4 meds)
- Doses exceed recommended maximum
- Prescribing more than one medication in the same class
- Prescribing that is inconsistent with current guidelines

Practice standards

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WWW.AACAP.ORG

STANDARDS FOR PRESCRIBING

- Complete a thorough evaluation
- Communicate with other professionals
- Develop a comprehensive treatment plan
  - Psychosocial supports when indicated
  - Plan for monitoring
- Obtain and document informed consent
- Provide a clear rationale for combination treatment
- Maintain a medical record

AACAP (2009) Practice Parameter on the Use of Psychotropic Medication in Children and Adolescents

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RECOMMENDED STANDARDS FOR SYSTEMS OF CARE

- Provide psychoeducational materials to facilitate consent process
- Establish child psychiatry consultation program:
  - "Red flag" markers signaling need for heightened scrutiny
  - Consultation to persons who are responsible for consenting for psychiatric medication treatment
  - Consultation to prescribers working with youth in child welfare
  - Provide face-to-face evaluations of youth at request of child welfare stakeholders who have concerns re specific youth's psychiatric med regimen

AACAP (2015) Practice Parameter for the Assessment and Management of Youth Involved with the Child Welfare System

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IDEAL STANDARDS

Establish programs administered by child psychiatrists to oversee and evaluate the use of meds at both the individual and population level

AACAP (2015) Practice Parameter for the Assessment and Management of Youth Involved with the Child Welfare System

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To help children, their families, and the child-serving systems of which they are a part, the Vanderbilt COE provides **direct clinical services, disseminates evidence-based and other best practices, and implements quality improvement projects.**

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Vanderbilt COE provides psychiatric consultation to DCS for red flag prescriptions

DCS RN submits clinical information to COE

COE physicians and nurse practitioners review and provide feedback

Provider consultation available on request

Contact us:
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