It’s a Big Deal: 
Appropriate Use of Psychotropic Medications with Children & Youth

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“Painting” A Shared Vision...

...to ensure the appropriate use of psychotropic medications with children and youth.
Who We Are

Magellan Health Services Inc. is a health care management company that focuses on fast-growing, complex and high-cost areas of health care, with an emphasis on special population management. Magellan delivers innovative solutions to improve quality outcomes and optimize the cost of care for those we serve.

Magellan is dedicated to ensuring that children and young people with behavioral health conditions and their families receive clinically appropriate care that supports them to successfully participate in all aspects of their lives.

Our Public Sector Division manages publicly funded services and supports.
Our Presenters

Gary M. Henschen, M.D. is chief medical officer-behavioral health for Magellan Health Services. In his current role, he directs a team that develops medical necessity criteria, new technology assessments, and clinical practice guidelines for behavioral health and substance abuse. He provides clinical expertise in new product development and Magellan’s quality improvement program. He oversees medical management for all of Magellan’s behavioral health programs. Dr. Henschen is a graduate of Davidson College. He received his Doctorate of Medicine degree from the University of North Carolina at Chapel Hill. He completed his internship in medicine at Letterman Army Medical Center, San Francisco, and completed military service with the U.S. Army in Germany, where he was flight surgeon and commander of the 536th General Dispensary. Dr. Henschen completed his residency and chief residency in psychiatry at Duke Medical Center. His research interests have included the assessment and prevention of suicide; psychiatric consultation and liaison with primary care physicians; the development of quality metrics; providing consultation to behavioral special investigation units, and the development of programs to screen for and treat substance use disorders.

Pat Hunt is the director of child and family resiliency services for Magellan Health Services. Pat’s role is key to Magellan’s fulfillment of resiliency and recovery throughout its operations and to the lives of the individuals it serves. Her responsibilities include promoting the meaningful involvement of families of children and youth; advancing family support and education; and highlighting the lived experiences of children, youth and their families to ensure that both policy and practice align with and support resiliency and recovery. Prior to joining Magellan, Pat held a seven-year senior leadership position with the National Federation of Families for Children’s Mental Health, with two years directing its office of policy. Pat has provided family support as a VISTA Volunteer. She directed a federally funded, rural substance abuse prevention project, and was the executive director of a statewide, family-run organization for children’s mental health.
Learning Objectives

At the conclusion of this presentation, the attendee will be able to:

– Discuss why there has been an increase in the use of psychotropic medications in children and youth.
– Differentiate treatment for symptoms vs. treatment for diagnoses.
– Discuss the 13 principles for prescribing to children and youth from the AACAP practice parameter.
– Teach parents important questions to ask their prescriber before accepting a psychotropic medication for their child.
– Teach practitioners important issues to review with the parent/caregiver before prescribing medication.
Social Context: What Impacts This Issue?

There is growing pressure on children to conform to strict behavioral standards in various settings. Behaviors that might have been seen in the past as a product of immaturity – and thus tolerated – are now seen as a problem that must be fixed quickly.

Authorities in schools, the courts and elsewhere often insist on a change in behavior immediately.

Parents are desperate to make things ok now.
– Peer experience – negative media approaches – effective advertising

Prescribers often have such busy practices that they are not able to balance pharmacotherapy with talk therapy. Appropriate psychotherapy and behavioral management therapies are often not available.

All of this leads to the perfect storm: Medication management as the primary answer to behavioral issues.
The Issue

Children and youth are still developing. Little is known about the impact of medications on their development.

Children and youth are being treated with psychotropic medications that have only been approved through clinical trials with adults.

Many children and youth are taking multiple medications without benefit of positive outcomes. The use of multiple prescriptions increases the likelihood of drug interactions and other adverse effects.

Side effects include weight gain, cardiovascular disease, insulin resistance, neurological and other issues.

Medications can prevent the development of psychosocial strategies and interpersonal skills.

Inappropriate use of medications can lead to false expectations from family, school personnel and other caregivers.
The Issue (continued)

Children and youth die as a result of inappropriate psychotropic medications.

Psychotropic meds have become a new source of supplemental income.

Psychotropic meds are related to crime and violence.

Psychotropic meds may be treating the prescriber rather than the patient.

This issue is everybody’s business!
Topics to be Covered

Research and impetus for change

Development process for Magellan’s clinical monograph

Using our monograph

Lessons/next steps
Why the Clinical Monograph?

Anxiety and confusion regarding use of medications in children.

Increased awareness of severe mental health problems in children.

Development of safer medications.

Increased experience of practitioners in treating younger children.

Increased behavioral expectations of very young children in settings.

Relying on medications alone can create problems as serious as the behavioral issues.

The monograph summarizes evidence-informed approaches to educate practitioners, families, consumers.
Marked Increase in Usage since 1990s

Zito et al, 2007; Zuvekas et al, 2006
– Increases in atypical antipsychotics and antidepressants.

Pidano & Honigfeld, 2012
– Increasing trend for male patients.

Olfson et al, 2006
– Six-fold increase between 1993-2002 in office visits that included prescriptions.

Cooper et al, 2004
Marked Increase in Usage since 1990s

Zito, 2008 — foster children study
– 12,189 out of 32,135 Medicaid recipients (37.9%) medicated with psychotropics.
– 15.9% — multiple psychotropic medications.
– Antipsychotics: Attention-deficit/hyperactivity disorder (ADHD), depression, anxiety/adjustment reaction at similar rate.

GAO report, 2012
– Medicaid members — twice as likely to receive antipsychotics than privately insured children/adolescents 2007-2009.
– Recommended increased initiatives to monitor and oversee.
– Continued assessment of psychotropic prescribing to vulnerable populations.
African Americans: Underserved

Zito et al, 1997
– Study of office-based physicians.
– African American youths 2.5 times less likely to receive prescription for a stimulant medication.

Melfi et al, 2000
– Less likely to receive prescriptions for antidepressants than Caucasians when first diagnosed with depression.

Dalton et al, 2009
– Less likely to be treated for mild/moderate depression and anxiety in juvenile justice settings.
Who is Prescribing Psychotropic Medications?

**Shute et al, 2000**

– Majority of psychotropic meds for children/adolescents in the U.S. written by primary care physicians, pediatricians.

– UNC survey: 600 pediatricians, family physicians
  • 72% prescribed antidepressants for children/adolescents.
  • Only 15% felt “comfortable” doing so.
  • Only 8% felt they had adequate training to treat adolescent depression.

**Patel et al, 2006**

– Psychiatrists prescribing also.

– Texas Medicaid youth: Psychiatrists accounted for > 80% of antipsychotic prescriptions.
Why are More Drugs being Prescribed?

Availability of new classes of drugs
- SSRIs.
- Atypical antipsychotics.
- Long-acting stimulants.

Changing federal regulations
- FDA Modernization Act: Loosened restrictions on promotion of off-label uses of medications (Buck, 2000).
- Television advertising spending increased six-fold (Rosenthal et al, 2002).

Changing clinical practice
- Low doses to minimize side effects.
- Choosing medications based on neurotransmitters, circuits and receptors (Stahl, 2013).
- This shift has contributed to polypharmacy and increased use of psychotropic medications.
Is this Change in Clinical Practice Appropriate?

**Walkup (2003):** Expanded use necessary. Pharmacotherapies increasingly effective.

**Olfson (2003) -** 1987-1997: Percentage of adolescents taking stimulants increased from 0.5% to 3.0%, but prevalence of ADHD in children/youth ~7%.

**Burns et al (1995):** 70% of children/youth who have a need for services do not receive them.

**Zito (2003b):** No data to support Walkup’s view.
- We don’t know if expanded use has gone to youths who need them.
- Little is known about the long-term treatment outcome of psychotropics in this age group.
- We don’t know enough about the benefit/cost ratio of the expanded use of psychotropic medications.
Increased Use of Medications: Good or Bad?

Lack of correlation between recorded diagnoses and medication usage:
– 30% of office visits involving prescriptions of psychotropics — no psychiatric diagnosis (Goodwin et al 2001).

**Angold et al (2000):** Diagnoses not reliable given non-standardized diagnostic procedures used.
So What is Being Treated?

Symptoms, behaviors disconnected from diagnostic categories.

**Impulsivity:** When associated with ADHD, should it be treated like bipolar disorder?

**Aggression:** When associated with conduct disorder, should it be treated like aggression found in affective disorders?

**Irritability:** When associated with oppositional defiant disorder (ODD), should it be treated like irritability associated with bipolar disorder?
An Additional Side Effect of Increased Medication Management

Increase in use of medications, decrease in psychotherapies.

**Martin & Leslie (2003):** 12.1% growth in medication costs per outpatient with concomitant decrease in outpatient therapy by 9%.
In Summary

**Ample evidence:** Increased use since 1980s.

**Evidence not clear:** Did this increase provide treatment for those who need it?

Children/adolescents in the US are both under-treated and over-treated with psychotropic medications.

Data regarding certain psychotropic prescribing causes concern, suggests that prescribing practices are sometimes questionable.
The Clinical Monograph

Work group reviewed current literature.

First draft reviewed, discussed with internal and external stakeholders.

Tip sheets allow easy reference to latest recommendations.

Bibliography up-to-date and extensive.

Can be used by Magellan care managers, medical directors in educating practitioners.

Can be used by advocates, parents, consumers to educate regarding appropriate use.
**AACAP Practice Parameter: 2009**

**Principle 1:** Before initiating pharmacotherapy, a psychiatric evaluation is completed.

**Principle 2:** Before initiating pharmacotherapy, a medical history is obtained and a medical evaluation is considered, when appropriate.

**Principle 3:** The prescriber is advised to communicate with other professionals involved with the child to obtain collateral history and set the stage for monitoring outcomes and slide effects during the medication trial.

**Principle 4:** The prescriber develops a psychosocial and psychopharmacological treatment plan based on the best available evidence.

Principle 5: The prescriber develops a plan to monitor the patient, short- and long-term.

Principle 6: Prescribers should be cautious when implementing a treatment plan that cannot be appropriately monitored.

Principle 7: The prescriber provides feedback about the diagnosis and educates the patient and family regarding the child’s disorder and the treatment and monitoring plan.

Principle 8: Complete and document the assent of the child and consent of the parents before initiating medication treatment and at important points during the treatment.

**Principle 9:** The assent and consent discussion focuses on the risks and benefits of the proposed and alternative treatments.

**Principle 10:** Implement medication trials using an adequate dose and for an adequate duration of treatment.

**Principle 11:** The prescriber reassesses the patient if the child does not respond to the initial medication trial as expected.

**Principle 12:** The prescriber needs a clear rationale for using medication combinations.

**Principle 13:** Discontinuing medication in children requires a specific plan.

The Magellan Clinical Monograph: Research Evidence

Mood disorders
- Bipolar disorder
- Major depressive disorder

Anxiety disorders
- Obsessive-compulsive disorder
- Generalized anxiety disorder
- Separation anxiety disorder
- Specific phobias
- Post-traumatic stress disorder (PTSD)
The Magellan Clinical Monograph: Research Evidence (continued)

Disruptive behavioral disorders/aggression

Attention-deficit/hyperactivity disorder (ADHD)

Autism spectrum disorders (ASDs)

Childhood schizophrenia
Effects on Nervous System Development

Developmental effects in utero.

Dynamic effects on immature brain — concept of plasticity.

Concept of neuronal imprinting.

Chronic exposure to medications at certain stages could be beneficial or harmful.

Future research needed.
Easy Reference Sheets

At-a-glance: Psychotropic Drug Information for Children & Adolescents

Psychotropic Drugs: Side Effects and Teratogenic Risks

Recommended Clinical Monitoring
The appropriate use of psychotropic drugs in children and adolescents

**THE CHALLENGE**
- 17 – 22% prevalence of children with mental health disorders
- 31% FDA-approved psychotropic medications for children
- 1 in 5 number of children receiving services from appropriately trained practitioners
- >75% prevalence of “off-label” (unapproved) use of prescriptions for children’s mental health treatment

**WHAT ROLE DO YOU PLAY?**
- Child’s physical and mental health practitioners
- Parent/caregiver
- Child = The child’s treatment team

**WHAT CAN YOU DO?**
- Asking questions is a good way to stay involved in your child’s treatment plan.

1. **The treatment options**
   - Are these medications needed?
   - Will my child benefit from therapy?
   - Did my child get a full evaluation from a behavioral health practitioner?

2. **The medication**
   - Has the medication been tested and approved for children? What are the risks, benefits, side effects?

3. **The treatment plan**
   - How will I know my child is making progress?
   - How often will my child be checked after starting the medications? What happens if we don’t see progress?
   - What warning signs should I look for and when should I call the doctor?
   - Will the treatment be noted in my child’s health care records?
   - Will you talk to my child’s other health care providers?
   - Do you know of other medications my child is taking and are there risks in combining them?

**GOAL:** to get the RIGHT treatment for each child’s needs.

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The Strategy

Magellan care management centers (CMCs) inform corporate-wide decisions and best practices

Global
Corporate effort across CMCs use policy brief & share best practices; develop new tools

Appropriate use of meds with children & youth
Better Outcomes

Application will inform more new CMC approaches

Local
CMCs identify point of impact & apply intervention(s); coordinate focus groups
Does This Issue Call for Policy Solutions?

Is anyone in your area developing policies to solve this problem? Are you involved in the effort? What solutions are being developed?

What solutions do you recommend?

Are there other tools that would help parents and youth meet the challenges we have discussed today?
Is Legislation or Regulation a Help or Hindrance?

Should primary care physicians be required to obtain a second opinion from a child psychiatrist or psychiatrist before prescribing psychotropics to children or youth?

Should health plans be required to institute prior authorization for prescribing psychotropics to kids?

Should off-label prescribing be prohibited entirely?

Can health plans be required to monitor off-label prescribing of these medications?

Can pharma be required to produce easy-to-understand guides for parents regarding medications?

Could medical boards require courses in psychopharmacology and mental health first aid as a requirement for license renewal?
Questions?

Link to post-test: https://www.surveymonkey.com/s/J7B9XFB

CE requirements must be completed by 5 p.m. Eastern Time on Tues., March 18, 2014

This course is eligible for 1.5 Continuing Education (CE) clock hours from:

1. American Psychological Association (APA)
2. Association of Social Work Boards (ASWB)
3. The Association for Addiction Professionals (NAADAC)
4. National Board for Certified Counselors (NBCC)

To receive your emailed CE certificate within 30 days, you must:

1. Complete all demographic questions
2. Complete and answer the post-test questions correctly
3. Complete the course evaluation

Additional resources related to Magellan’s clinical monograph are available here.
Questions?

If you have any additional questions that were not addressed during the presentation, please contact either of the presenters:

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Bibliography


Bibliography


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