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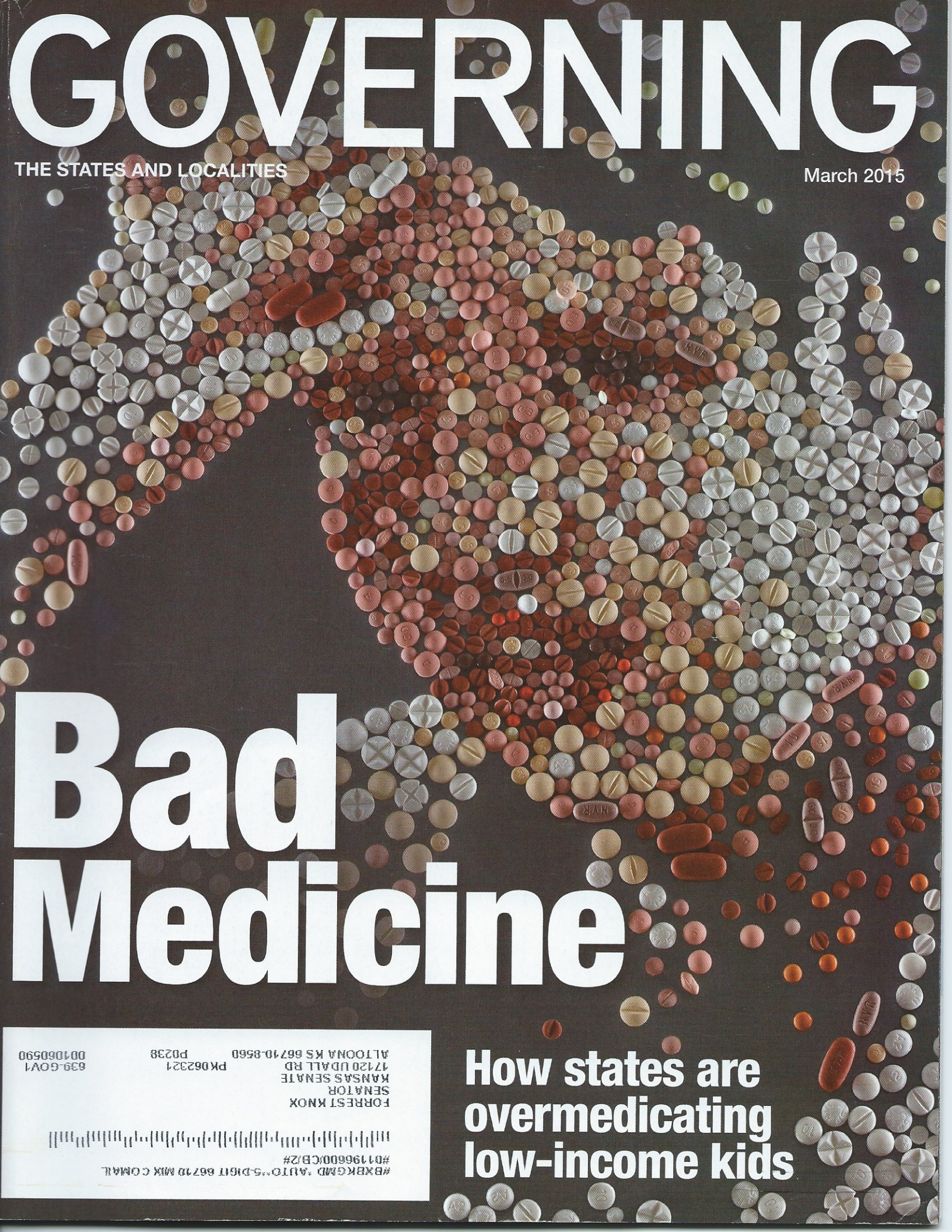

Bad Medicine

How states are overmedicating low-income kids

An alarming rise in the use of psychotropic medicine for low-income children has states scrambling for solutions.

By Chris Kardish

'We're Medicat Povert

Allen Brenzel, a child psychiatrist in Lexington, Ky., can point to the moment he knew his state had a drug problem. A few years ago, Brenzel was working as a consultant for a residential treatment facility for kids under state custody. During his time there, he became acutely aware that many of the children in the program were on prescriptions for psychotropic medications—and lots of them. "It was not uncommon for me to see children as young as 10 or 12 on three or four psych meds," Brenzel says. "That became more the norm than the exception." But it was seeing a little boy no older than 5 who was on four different psychotropic drugs that still stands out today in the psychiatrist's mind. "I remembered thinking you shouldn't be on more medications than your age."

Brenzel says he knows that sounds glib, but it drives home a crucial point. Children in the United States are on drugs for longer and more often than kids in any other country. And for children on Medicaid or in foster care, the numbers are far higher. In Kentucky, for example, a child in the Medicaid program is nearly three times as likely to be prescribed a mind-altering psychotropic medication as a kid under private insurance. For a Kentucky foster child, the likelihood is nearly nine times the norm.

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Kentucky is hardly alone in overprescribing psychotropics, a class of drugs that ranges from stimulants to antidepressants and antipsychotics. Between 1997 and 2006, American prescriptions for antipsychotics increased somewhere between sevenfold and twelvefold, according to a report by the University of Maryland. And just as in Kentucky, the nationwide numbers for children in foster systems or on Medicaid are startlingly higher than for other children. An average of 4.8 percent of privately insured children are prescribed these drugs every year; among kids on Medicaid, the number is 7.3 percent, according to the most recent study, which looked across 10 states. For children in foster care, it's a whopping 26.6 percent.

For many physicians and psychiatrists, it's a situation that's gotten out of control. "We've reached the limits of medicalization," says Julie Zito, a professor of pharmacy and psychiatry at the University of Maryland. "We're medicating poverty."

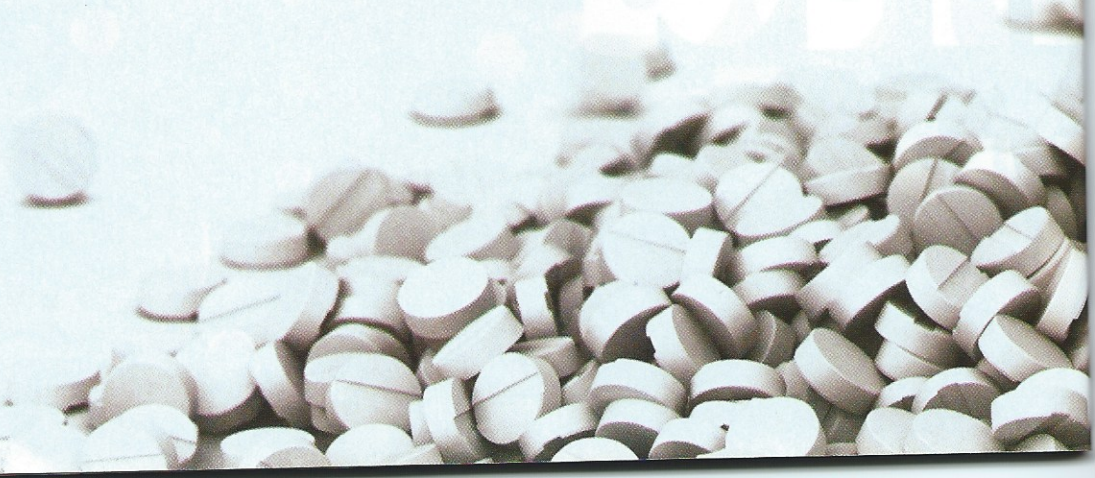
States have begun to act. Spurred by a series of federal probes and a 2011 directive to begin reporting on the steps they're taking to reduce prescription rates, state health officials have tried a variety of approaches to address the problem. What they've found is that it's an enormously hard battle to fight. Some places, like Kentucky, are just getting started; others are finding that the efforts they have taken aren't enough. And it's not simply about monitoring prescriptions. To make real inroads, states must focus on providing greater access to drug alternatives and on fixing a fragmented system of care. "We know what works," says Sheila Pires, founder of the Human Service Collaborative, a group specializing in child and family service systems. She points to things like individually tailored pyschiatric therapy programs and family support groups, all connected through people who coordinate the full range of a child's needs. "The challenge has been getting sufficient service capacity and care coordination across the systems—behavioral health, Medicaid and child welfare."

And it turns out that's a whole lot harder.

270%

Increase in the number of antipsychotic prescriptions for Medicaid children in Kentucky between 2000 and 2010.

Today, about five years after first getting a glimpse of the problem, Brenzel is now tasked with helping fix it. As Kentucky's medical director for mental health, he's overseeing an initiative that combines better access to therapy for children with better state monitoring of the prescriptions that are doled out. Brenzel and others suspect that many of Kentucky's prescriptions come from primary care physicians who haven't performed compre-



hensive assessments to prove the drugs are appropriate. So he has been meeting regularly with University of Louisville pediatricians and the state's privately run Medicaid organizations to develop a unified strategy to ensure that doctors prescribe psychotropics only when necessary. In the meantime, the state has told its Medicaid organizations to come up with prescription-limiting proposals to put in place this year. "We've said to them, 'We have a problem, which means you have a problem,'" Brenzel says. Next year, he plans to have the data "to say this worked or that worked."

The depth of Kentucky's problem really came into focus in 2012. A researcher at the University of Kentucky found that antipsychotic prescriptions for Medicaid children had increased 270 percent from 2000 to 2010, compared with 53 percent among adults. That report made headlines; the state secretary for health and family services at the time called it "disturbing." Kentucky was impelled to take action.

Of all psychotropic medicines, it's antipsychotics that raise the most concerns among experts. They were once only prescribed to manage symptoms of schizophrenia, bipolar disorder and other severe forms of mental illness. But in the 1990s, a new generation known as "atypical antipsychotics" promised better results with fewer side effects (both claims have been disputed), and aggressive marketing made them a common fix for routine depression and anxiety.

There is no FDA approval for the use of antipsychotics for children. Nonetheless, children over the past decade have increasingly been given antipsychotics to combat aggression and other behavior problems. It's fairly common for doctors to prescribe drugs that haven't officially been approved for children, in part because FDA trials rarely extend to kids. Still, the long-term impact of psychotropic drugs on young minds isn't known. And it's reasonable to suspect that drugs that deliberately stimulate chemicals in rapidly developing brains will have significant effects, says Stephen Crystal, a Rutgers University professor who has produced some of the most widely cited research on the growth of antipsychotics in children. "You cannot randomize either ethically or practically a group of kids on an antipsychotic and one group on placebo for 10 years and follow them. So we don't know the effect on cognition, emotional regulation," he says. "They're complete unknowns."

3x

Amount by which a Kentucky child on Medicaid is more likely to be prescribed a psychotropic medication, compared to a child under private insurance.

While Kentucky is trying to rein in prescriptions among Medicaid recipients, it's also taking steps to address the problems among its foster care population. State officials are considering something called a second-opinion review for psychotropic prescriptions, which would add a level of greater medical expertise either from within the government or academia. There's another, somewhat similar backstop known as prior authorization, which requires doctors to make their case to the authorizing agency as to why the drug is necessary. At least 14 states require prior authorization for some forms of psychotropic drugs, mostly antipsychotics. But for now, it's a measure that Kentucky isn't pursuing. Many in the medical field object to prior authorization as an oversight

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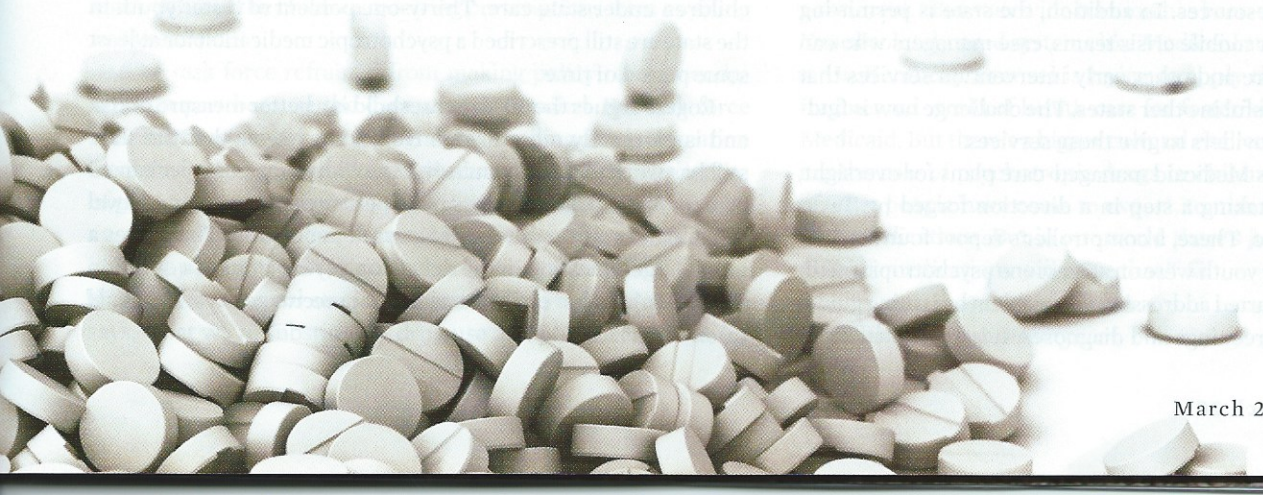

Children in the United States are on psychotropic drugs for longer and more often than kids in any other country.

tool. They find it intrusive and overly broad, and they claim there is no strong evidence that it's an effective tool for moderating prescription rates. That may be true in a broad sense, but there is academic research that shows the method can have a statistically significant effect specifically regarding antipsychotics.

Brenzel's other focus is on the more intractable problem of "fragmented" care in a system where kids accumulate prescriptions from setting to setting and doctors feel reluctant to challenge what someone else has prescribed. Kentucky is attempting to better diagnose these children by ramping up comprehensive behavioral screenings for foster kids through a federal waiver that allows the state to pay for reimbursement. The state is also letting Medicaid patients seek mental health care outside limited state-run community centers, which will help bolster access to a wider range of resources. In addition, the state is permitting Medicaid to pay for mobile crisis teams, case managers who can help coordinate care and other early intervention services that have proven successful in other states. The challenge now is finding and training providers to give those services.

By leaning on its Medicaid managed-care plans for oversight, Kentucky will be taking a step in a direction forged by Texas nearly a decade ago. There, a comptroller's report found nearly four out of 10 foster youth were on at least one psychotropic medication. The state started addressing the problem by issuing guidelines on dosage, screenings and diagnoses. It has updated those parameters numerous times and requires managed-care plans to review individual cases that fall outside the usual norms. Some of the parameters—which are increasingly common in other states—that can automatically trigger a review include the absence of a psychological diagnosis; the use of multiple drugs at the same time; the prescribing of an excessively high dosage; and the prescribing of psychotropics to very young children.

Child psychiatrists and outside consultants in Texas review the information, which follows each child through an electronic record known as a "health passport." If patterns emerge, those doctors whose prescription practices appear suspect could, upon further scrutiny of the records, be removed from the Medicaid network. The last time that happened was 2012, notes James Rogers, the medical director of the Texas Department of Family and Protective Services. Some states go further. Illinois, for example, reviews prescriptions before they're filled, utilizing university partners who make recommendations to child welfare agents. Texas doesn't do that, and Rogers won't say one method is better than the other. But he does say he wants to avoid being heavy-handed, or as he puts it, "directing cases from a helicopter." It's a concern echoed by officials elsewhere, who say they don't want to discourage doctors from taking on more challenging patients.

Texas' method has produced results. For foster kids, prescriptions for psychotropic medications for longer than 60 days have decreased by more than a third since 2004, to 19 percent of the foster care population. The use of multiple prescriptions has fallen 71 percent. In a 2012 study of antipsychotic prescriptions across 47 states, Texas was one of only two to lower its rate among foster youth between 2002 and 2007. (The other was Hawaii.) But Texas' prescription rates are still staggeringly higher for those children under state care: Thirty-one percent of foster youth in the state are still prescribed a psychotropic medication for at least some period of time.

Rogers argues the 60-day threshold is a better measure of risk and is ultimately more useful. He acknowledges that the state still has work to do, particularly in providing trauma-specialized care for foster youth. But he says 19 percent is approaching a level he thinks is appropriate for the overall population. That raises a much larger question in the debate on psychotropics, a question that doesn't yet have consensus: What percentage of youth *should* be on them?

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The reality is that some kids can benefit from some psychotropic medications at some point in their lives. At least that's the opinion of many state medical professionals. And it's not wholly unreasonable that rates would be somewhat higher among foster children and kids in low-income families. After all, nearly half of all children who come into contact with a child welfare agency in the U.S. have a "clinically significant emotional or behavioral" problem, according to a 2013 University of New Hampshire report. Prescribing "off-label," or outside the FDA approved uses, has always been commonplace in pediatrics. Indeed, various studies have shown that more than two-thirds of prescriptions for children are technically off-label. "To come up with, 'Oh, they should never be prescribed to anyone under age 18' is way off the mark," says Robert Hilt, a child psychiatrist who directs Washington state's third-party psychotropic review program, which has helped lower antipsychotic prescriptions by 35 percent in foster children and 9 percent in Medicaid overall since 2009. The fact of the matter, he says, is that some children with severe psychological problems may benefit from taking these medications for at least a short period.

Even noted experts like Crystal admit it's hard to say what exactly is appropriate, although there is widespread agreement that prescription rates are definitely too high in many states, both for foster kids and in Medicaid more broadly. Still, Anna Johnson, an analyst at the National Center for Youth Law in California, argues that the goal for antipsychotics should be zero percent prescribing off-label, given the unknowns about long-term effects. Johnson's organization, along with the Bay Area News Group, recently helped bring to light data that show nearly 1 in 4 adolescents in foster care over the last 10 years in California received psychotropic medications, despite mandatory prior approval from juvenile courts. The state has had a psychotropic drug improvement task force for more than two years. But it has yet to make recommendations, so Johnson's organization will be pushing legislation to bolster clinical expertise within the court system and boost therapeutic alternatives.

States know the problem of overprescribing extends beyond foster systems, affecting other low-income children as well. In Connecticut, for instance, data emerged last year from a children's mental health task force showing that the percentage of youths on Medicaid who had been prescribed antipsychotics had doubled just since 2008. The report also showed a threefold increase in amphetamine prescriptions and a fourfold increase in antidepressants. Some of the children receiving prescriptions were as young as 3 years old.

The task force refrained from making policy recommendations, in part because the data weren't detailed. But task force members say simply retrieving and compiling the information from various vendors and agencies underscored the challenges of getting a handle on prescribing. State Rep. Diana Urban, who co-chaired the task force, says the difficulty of finding data to identify potential overprescribers is a challenge—but so is the lack of psychological services. "I just have to be suspicious," she says, "that we're substituting drug use and pharmaceuticals for psychiatrists and psychologists and in-home treatment early on in the kids' lives."

1 in 4 Number of foster kids nationally prescribed at least one psychotropic medication.

It's that part of the solution that has proved most elusive to states but is perhaps most essential in the long term. Experts say the right programs already exist, but they've yet to reach wide use. Those ideas include intensive in-home services with psychiatric professionals, family and peer support programs, individualized behavioral management plans and the help of medical professionals who coordinate a child's needs across the system.

If that sounds complicated and difficult to implement, it's because it is. One place that offers hope for success, though, is New Jersey. That state began building just such a system in the late 1990s, starting with just a few counties; statewide implementation was completed in 2006. It's certainly had a financial benefit: Since statewide rollout was completed, New Jersey estimates it saved $40 million in a span of three years by drastically reducing the number of children placed in long-term institutional care facilities. But experts say the New Jersey model—with its focus on targeted, personalized psychiatric care—is also the key to reducing psychotropic prescriptions.

The kinds of services offered in New Jersey can be covered by Medicaid, which means a state that wants to implement them can take advantage of federal matching rates. "More and more states are trying to move in this direction, and there are pockets of innovation in almost every state," says Pires, the human services consultant. "But statewide traction has been a little harder to get. You absolutely need systems like Medicaid at the table to agree."

In Kentucky, Brenzel is trying to apply those lessons to the fragmented world of health care for foster kids and children on Medicaid. But there's a bigger cultural challenge, he says, regarding the role of psychotropic drugs in children's lives. "It's part of what people have come to expect, to manage these problems with medications. But in our world there's just really no reason to think medications will solve that." G

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