Welcome to the training program on Best Practices in the Use of Psychiatric Medications for Youth during Residential Interventions. This training program is one of a number of training modules developed by the national Building Bridges Initiative in 2014 to support all stakeholders — including leaders and other staff of residential and community programs that interface with residential; policy makers; advocates; and families and youth, in continuing to improve practice so that all families and youth served by residential interventions realize sustained positive outcomes post discharge. This training program was developed by Dr. Christopher Bellonci. His contact information is included on the last slide of this presentation.
Building Bridges Initiative (BBI) Mission

Identify and promote practice and policy initiatives that will create strong and closely coordinated partnerships and collaborations between families, youth, community- and residentially-based treatment and service providers, advocates and policy makers to ensure that comprehensive services and supports are family-driven, youth-guided, strength-based, culturally and linguistically competent, individualized, evidence and practice-informed, and consistent with the research on sustained positive outcomes.

Building Bridges Initiative (BBI) Mission

The Building Bridges Initiative – often referred to as BBI - is a national initiative to ensure strong partnerships and collaborations between families, youth and all stakeholders involved in supporting them; the goal is to implement a range of promising, best, evidence-informed and - based practices that lead to sustained positive outcomes for the youth and families who are served by residential programs and their community counterparts. The outcomes are not - just that the child will ‘get better’ while receiving the residential interventions – but that the services and supports provided by the residential program, in collaboration with their community services and support partners and family and youth advocates, will result in each child and family being able to successfully live together in the community 1 year, 2 years, 3 years post leaving residential.
Building Bridges Initiative Core Principles

The Building Bridges Initiative – or again BBI - has a set of principles that are steeped in the research on sustaining positive outcomes for youth and families with multiple challenges. BBI has worked for the past 10 years to bring the field documents that operationalize into practice these principles – in order to support all stakeholders in realizing better outcomes for youth and families. BBI has focused most attention to date on the principles of family-driven and youth-guided care – as these two principles serve as the very foundation for effective residential interventions. The Building Bridges Initiative, with these different training modules, is building on the documents and tools that BBI has already developed and shared with the field. Please go to the BBI website to find the many documents available that will support your programs in implementing practices that lead to sustained positive outcomes for youth and families. The last slides of this training module provide you with examples of some of the tools available, as well as contact information to learn more about BBI, and for this specific training module on best practices in medication.
Best Practices in the Use of Psychiatric Medications for Youth during Residential Interventions.

Training Goals:
At the completion of this training on best practices in the Use of Psychiatric Medications for Youth during Residential Interventions, the participant will:

• Understand what is known about the use of Psychotropic meds during residential interventions.
• Be able to consider how time spent in residential interventions can be an opportunity for thoughtful diagnostic and medication reassessment.
• And Evaluate the role of the prescriber working with youth and families during residential interventions and identify Quality Improvement measures for tracking medication utilization during residential interventions.

Throughout this presentation the term “Youth” will be used to refer to both children and adolescents.
Acknowledgements

Much of the content for this presentation comes from an American Association of Children’s Residential Centers (AACRC) paper: *Redefining Residential: Towards Rational Use of Psychotropic Medication*. Authors: Mohan Krishnan, Christopher Bellonci, Robert Foltz, and Robert Lieberman. The entire paper can be accessed at aacrc-dc.org under the section on position papers. Dr. Bellonci also thanks Beth Caldwell for her thoughtful edits.
Psychiatric Utilization Rates

There has been an exponential increase in the use of psychiatric (also called psychotropic) medications for ALL youth over the last decade.

According to a 2014 survey by the National Center for Health Statistics, 7.5% of youth in the United States between the age of six and seventeen years old were prescribed a medication for emotional or behavioral difficulties.

Youth on public insurance (Medicaid) are prescribed psychiatric medications at a higher rate than privately insured youth, 9.9% versus 6.7%.

Youth in the child welfare system are prescribed psychiatric medications at rates several times higher than non-foster youth.

This means that youth who are referred for residential interventions are likely to be taking significant amounts of psychiatric medications, much more than just a decade ago.
Research lags behind prescribing rates

A key point of this presentation is that we are using increasing amounts of psychiatric medications for youth, particularly foster youth, while the research that would support such use is, in many cases, still being developed.

The majority of psychiatric medications used with youth have not been tested for safety in this age group or been shown to have efficacy for the specific psychiatric conditions they are prescribed to treat. Efficacy refers to whether the medication works for the indication or condition it is being prescribed to address.

Another concern is that some medication classes, such as atypical or second-generation antipsychotic medications carry significant risks of side-effects including diabetes and heart disease. Research shows that we are doing a poor job of monitoring for these potential side-effects and these are one of the fastest growing psychiatric medications prescribed to youth.
Polypharmacy, or taking more than one psychiatric medication at a time, is also on the rise.

These trends are being seen throughout the service array, including in residential programs, where youth are admitted on increasing numbers of psychiatric medications.
Residential as an Opportunity to Reduce Medications

A residential intervention provides an opportunity to carefully reassess the medication regimen a youth is taking in the context of an environment that should be using sophisticated behavioral data to track response to interventions and has access to alternatives to a medication-focused treatment such as evidence-informed and evidence-based interventions for families and youth; special education supports; behavioral and emotional supports, trauma-informed interventions, etc.
Trauma-informed assessments

In our work with youth, it is important that we take a “trauma-informed” approach including using trauma-informed assessments of all youth in order to properly screen and identify youth who have been impacted by trauma.

This is necessary since many youth with trauma are mistakenly diagnosed with other psychiatric conditions, such as Bipolar disorder and then put on medications that are not helpful in addressing the primary underlying condition such as Post-traumatic Stress Disorder or PTSD.

In fact, there are no approved medications for the treatment of PTSD although some research suggests Selective Serotonergic Reuptake Inhibitors or SSRI’s, medications such as Prozac, Zoloft or Celexa, may be helpful. The key word here is ‘may’. There are many other psychosocial interventions that have evidence for treating trauma – nearly all of which include work with the family or caregiver simultaneously.
Using evidence to guide treatment

Treatment should be based on the best available evidence for the specific condition and age of the youth. For example, for mild or moderate depression or anxiety, therapy should be tried before meds. In severe anxiety or depression, in cases resulting in hospitalization or in cases involving mania or psychosis, medications should be started concurrently with the initiation of an evidence-based therapy.

Residential interventions should focus on teaching youth and their families skills to manage and cope with their feelings, emotions and behaviors.

If the condition and acuity of the youth warrants, medication should be a part of their treatment but it would be extremely rare to have a youth on a psychiatric medication in the absence of an evidence-informed or evidence-based psychosocial intervention. The literature indicates that what we do to support and educate families is actually more critical to achieve sustained positive outcomes post residential than what we do with youth. It is imperative that all clinical staff have skills at engaging and working successfully with families. This again is the FIRST LINE of treatment.
Teaching competency

Residential interventions provide an opportunity to teach competency to youth and families, not merely treating symptoms.

By learning skills both in the residential program and with their families at home and in the community, youth develop the capacity to overcome their fears and feel more competent, skills they can take with them after discharge and put into action in their home, community and school.
Family-driven, Youth-guided

Prescribers in residential settings need to partner with family members and youth in their care in determining the goals of the treatment and the role medication will play in achieving those goals.

This may include such things as shared writing of the treatment plan and discharge summaries.
Initial Assessment

Behavior is a form of communication and our work is understanding what the youth is trying to communicate through their behavior. During the initial assessment, Residential prescribers should understand the basis for the youth’s behavior taking into account their lived experience including:

- any trauma they may have experienced;
- cultural and social factors influencing or impacting the meaning of their behavior; and
- ways in which the behavior may have been “functional” in response to environmental stressors and now needs to be “unlearned”.

Often a youth’s behavior makes sense given their past experiences and the work is helping the youth to realize the behavior is no longer needed in their present circumstances.
Longitudinal Assessment

On-going reevaluation of the clinical formulation or understanding of the behavior, while monitoring response to treatment, will lead to a refinement of the diagnostic picture over time, yielding a more complete understanding of the youth and their treatment needs.

A residential intervention provides an opportunity to conduct a longitudinal assessment of the youth. Once you decide on a diagnosis and develop a treatment plan based on that diagnostic assessment, you should gather data to see if the interventions are working and if not, endeavor to understand what is the barrier to progress.

This is similar to the familiar quality improvement approach of “Plan, Do, Study, Act.”

Once you decide on a diagnosis and develop a treatment plan based on that diagnostic assessment, you should gather data to see if the interventions are working and if not, endeavor to understand what is the barrier to progress.

Is it too early to see results? Is the intervention not the right fit for the youth or family? Or do you have the wrong diagnosis? Don’t be afraid of questioning your initial diagnostic conclusions.

Diagnoses are hypotheses meant to be reassessed as additional data is made available.
Shared decision-making

A holistic approach to addressing presenting problems should be developed through family driven, youth guided, person-centered planning, in which the prescribing physician, youth, family, staff and others all have equal input into the treatment planning.

This represents a paradigm shift from the traditional model of “physician knows best”.

In most cases, families and youth “know best”, THEY are the experts of their child and themselves.
Holistic approach

It is best to use a holistic approach where psychototropic medications are regarded as just one option within a constellation of clinical strategies that can improve the youth's functioning and overall outcome.

It is important to avoid a pharmacological vs. non-pharmacological dichotomy, which may unintentionally ascribe greater importance to psychototropic medications over other interventions, therapies and support strategies or vice versa.
Informed Consent

- Youth and families should be fully involved in making and supporting both pharmacological and non-pharmacological treatment and support decisions.
- It is critical that youth and families are provided psycho-education regarding medication, that their attitudes towards and beliefs about medications are respected, and that open dialogue is encouraged.

The prescriber’s responsibility is to make their knowledge available to the youth, family and residential staff so that the youth and family can make an informed choice about their treatment, including whether and which medications to consider.
Youth responses to medication will be variable.

Some examples of youth’s response to a psychiatric medication trial may include:
- Over and/or under reporting of benefits and side-effects;
- Medication refusal;
- Fear of sacrificing control;
- Seeing medication as a way to fix the problem;
- Reduced investment in learning new ways of managing frustration, disappointment, and anger.

Family members may have a similar range of hopes and fears about medication.

We probably don’t talk enough about the “meaning” of taking a medication.

Psychiatric medications are not benign interventions. They have meanings for the youth and family and it is important that we discuss and understand those meanings so they don’t become unspoken barriers to getting to wellness.
Avoid coercion.

When a youth and/or family feels uncomfortable or opposes the use of psychotropics, they should not be forced.

Subtle or overt pressure is contrary to family-driven, youth-guided and trauma-informed care.

Adequate support and monitoring should be provided for youth and families interested in reducing dosage levels or numbers of medication.

This is contrary to how most residential interventions are structured where the youth is expected to comply with their program rules. In many settings this translates to negative consequences for refusing to take a medication.

Youth should understand the rationale for the medication and be active participants in their treatment. When done well, this will reduce the incidence of medication refusal and enhance the likelihood of seeing a positive response to the medication trial.
Use the lowest, effective dose of a medication.

Prescribing clinicians must carefully weigh the potential benefits and risks of medication class, dosage, and polypharmacy, all of which can increase the likelihood of side-effects.

Medication side-effects are dose-dependent, meaning the higher the dose, the more likely you will experience a side-effect.
Medication Oversight

Programs may wish to work in partnership with their prescribing providers to create **formal protocols** that require review or justification of some instances of increased medication, in order to ensure that risks are being adequately considered and that lower-risk alternatives, such as skills-focused, sensory, family or peer support interventions have been ruled out before more medications are added.

This again represents a paradigm shift where the work of the prescriber within a residential setting has typically not been a part of the quality improvement program.

In fact, there is no reason psychiatric medication practices should be excluded from a residential program’s on-going quality improvement initiatives. It is relatively easy to set up prescribing practices that might trigger a review about a child.

For example, taking three or more psychiatric medications at a time; or taking two medications from the same class; or prescribing to a child under a certain age; or a child continuing on a medication for longer than 6 months despite improvement in their functioning.

Any of these circumstances might trigger a conversation between clinical administration, the family, the youth, the funder and the prescriber about whether there is an opportunity to reassess the need for a medication.
Limit duration of exposure

Limit the duration of exposure to psychiatric medications in order to minimize side-effects.

Rational use of medication also must attend to duration of psychotropic treatment.

Longer-term treatment regimens are sometimes utilized based on research of short-term outcomes, despite emerging evidence of potential risks of such sustained usage on the developing brain and body.

Most of the research on psychiatric medications for youth were based on studies lasting just 6 to 8 weeks. Therefore, we lack sufficient data about the impact of taking these medications for months or years at a time which has become common practice for youth receiving residential interventions.

This is an additional reason to use the residential intervention to teach skills and identify supports to address the behavior resulting in the residential intervention while reassessing the medication regimen.
Add Meds Oversight to other Clinical QI Initiatives

Residential settings should consider adding medication oversight to their other quality improvement initiatives.

Careful monitoring of the impact of medication trials will improve outcomes.

Program monitoring protocols can assess:
- The types of medication being used within the residential setting;
- The number of medications a single youth is taking;
- The dosage of the medications prescribed to ensure it complies with FDA dosage guidelines if available;
- The duration the youth has been prescribed a specific medication or medications;
- The overall utilization rates of psychiatric medication or whether youth are being discharged on less, more or the same number of medications;
- And the pattern of side-effects youth are having within the residential setting.

Additional monitoring practices may include automatic review and engagement for “outlier” prescribing patterns, and the degree to which alternatives were considered or rejected prior to certain higher-risk prescribing actions.

To achieve these QI goals, peer consultation or peer review from a child and adolescent psychiatrist outside of the residential program may be needed. There are also practice parameters and clinical guidelines that have been developed by professional societies that define the standard of care (see American Academy of Child and Adolescent Psychiatry’s Practice Parameters at AACAP.org).
Data to Inform Practice

Physicians must play an active role in using data to inform practice – carefully analyzing and being transparent about the use of medications. They should support residential leaders in incorporating data about medications into dashboards, reports to the community, information provided to parents and youth about the program or other high-visibility venues.

This will have the important impact of setting a tone within the program and beyond that quality concerns related to medication practice are at least as important as any other aspect of quality improvement.
Caution on the Use of Data

Caution needs to be exercised regarding the use of data.

Data-driven practice only works in an environment that has operationalized best practice values of Family-driven, youth-guided, trauma-informed and strength-based and individualized care.

Prescribers need to work with family members on observations as well as youth’s own feedback and observations as part of your data collection.
Track Response to Interventions

A system for clear and consistent communication of favorable, insignificant, or adverse responses to medication trials to the youth and family, and all involved team members is critical, particularly given the number of individuals involved in the youth’s care and treatment, and the concomitant risk of communication breakdowns.
Training and Education

Residential programs need to think about the training and educational needs regarding psychotropic medications.

Psychotropic medication training should be provided for:
- Employees at all levels,
- Youth and families,
- advocates, funders, and external stakeholders;

With a goal of developing an understanding of both reasonable expectations and limitations to psychotropic medication use, as well as the range of potential adverse effects.

The outcome of such training will be to elevate the perceived and actual importance of monitoring and communicating regarding medication response, drug interactions, etc.
Empowering Youth

Youth receiving residential interventions have often lost their voice and had few choices in what has happened to them, rather it was trauma and/or having trouble learning and/or having emotional and dys-regulation challenges and/or a multiple of other factors. They have no choice about not living in a normal environment with their families and in their communities as their peers do. It is the responsibility of every staff working in residential programs to focus on youth empowerment - through promoting their voice and choice. This happens through engagement strategies and offering education and support.

- With medication, Youth should understand and, in a developmentally appropriate way, assent to their treatment.
- This means youth should understand what the medication is meant to help with; how long they should wait to see benefits and what side-effects to watch for.
Don’t Discount Resiliency!

Childhood is a time of rapid developmental changes. Don’t discount the power of resiliency to benefit a youth.

Youth change over time in response to their ongoing experience.

Behaviors that may be considered maladaptive at one age may be developmentally normal at another, which will influence medication decision making.

Development of resiliency, executive functions, and coping abilities will result from treatment or simply maturation, and medications that are “necessary” early in an episode of care may need to be reconsidered periodically.
Work with the Outpatient Team

Residential settings should be working with the youth and family’s outpatient team.

Residential interventions are occurring in shorter stays.

The residential prescriber should work with the outpatient prescriber in a shared-understanding of the youth’s strengths and needs.

The outpatient prescriber should be kept informed of medication changes so there are no surprises at discharge.
Discharge Planning

Discharge planning should be occurring from the moment a youth is referred for a residential intervention.

In order to minimize post-discharge instability in medication use, residential staff need to ensure the youth has a secure and consistent means of obtaining their medication; getting to outpatient appointments; continuing their treatment and supports; and a means of getting back in touch with the residential staff to ask questions about their past treatment.

Residential prescribers must take into account the reasonable ability of the post-discharge setting to support medication adherence, and address how post-discharge monitoring and revisions of psychotropic regimens will occur.
The youth and family should be provided a summary of the interventions, supports and services that were found to be effective during the residential intervention.

A similar summary should be provided to the outpatient team, allowing for better bilateral communication of lessons learned and improvements in the youth and family’s functioning.
Shared Decisions, Full Participation, Mutual Responsibility

- It is difficult to implement changes in treatment practices and processes, and team members may not be able to fully support change due to the perception that changes may limit their clinical options.
- Residential staff may feel that medications that would help manage difficult behavior is being arbitrarily withheld.

The goal is to facilitate shared decision-making, full participation and mutual responsibility towards meeting the goals of the residential intervention by ALL members of the team including the youth, their family, the residential staff including the prescriber, the outpatient team and any other identified team members including both formal and informal supports the family identifies.
Prescribing clinicians and administrators may be uncomfortable with monitoring and oversight of medication practices, which may feel burdensome and an unwarranted intrusion into independent practice.

Youth and family members may be confused by the different approach from that which they’ve experienced or by the ambiguity involved in the careful evaluation of medication regimens.
Physician Leaders

Realizing this promise will involve developing physician leaders who believe in this approach and can influence their peers towards rational psychotropic medication use.

It will be important for other leaders, including administrators, clinicians, and advocates, to actively engage physicians and other prescribing practitioners in understanding the rationale for these practices and how they support shared treatment goals.
Wellness is the goal!

According to the World Health Organization, Health depends on the presence of wellbeing, and not only the absence or management of disease.

A rational approach to the use of psychotropic medication can stimulate a focus on strengths and needs and allow the team to pursue the overarching goal of youth wellness that is really everyone’s objective.
Change the Paradigm!

It is time to change the paradigm of how medications are utilized during residential interventions.

Doing so will promote increased use of family-driven and youth-guided practice and facilitate youth and families in becoming much more able to see themselves as agents of their own change as opposed to their relatively passive role in the traditional medication compliance regimen.
Select References

Thank you for your participation in this webinar. The next several slides list selected references from the presentation.
Select References


Select References

Select References

And go to the BBI website to find a number of other documents to support you in your efforts to better serve families and youth. Examples of documents to be found include those listed on this slide.
BBI Contact Information

Please feel free to contact the developers of this training module, Dr. Christopher Bellonci, if you have questions about this specific training module. Please also feel free to contact Dr. Gary Blau or Beth Caldwell if you have any questions about the national Building Bridges Initiative and/or if you would like to be put on the BBI List Serve so you can receive regular updates about BBI, and be the first to receive new documents developed to support the field and invitations to BBI events. Thank you so much for taking the time to watch this training program and for your obvious interest in positive outcomes for youth and families who receive residential interventions.

Also – please contact either Dr. Gary Blau or Beth Caldwell if you would like to learn more about BBI or join our BBI list serve.
Thank you for taking the time to participate in this training module. Keep up your good work!
Congratulations!
You have completed the Building Bridges Initiative on Best Practices In The Use Of Psychiatric Medications For Youth During Residential Interventions. Please use the navigation below to complete the post-test.