Getting It Right: Improving Access to Behavioral Health Services and the Appropriate Use of Psychotropic Medication for Children and Youth

Kamala D. Allen, MHS, *Center for Health Care Strategies*  
Christopher Bellonci, MD, *Tufts University School of Medicine and Judge Baker Children’s Center*  
John H. Straus, MD, *Massachusetts Behavioral Health Partnership*
Agenda

• Introductions and Context Setting
  Kamala Allen, MHS

• Trends in the Use of Psychotropic Medications for Children and Youth with Behavioral Health Challenges
  Christopher Bellonci, MD

• Children in Foster Care and Psychotropic Medications: A Special Needs Population
  Kamala Allen, MHS

• Building a Psychiatric Consultation Program: Lessons from Massachusetts and Beyond
  John Straus, MD

• Implications for Practice
  Christopher Bellonci, MD

• Question and Answer

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Learning Objectives

1. Understand the nature of behavioral health service use and expense for children and youth.
2. Understand trends in the use of psychotropic medications.
3. Understand the concern regarding psychotropic medication use, and populations at highest risk.
4. Understand the role of effective oversight and monitoring of psychotropic medications use.
5. Become familiar with the key characteristics of Child Psychiatry Access Programs through the Massachusetts model.
What’s the Problem?
Behavioral Health Care for Children, Youth, and Young Adults: Federal Guidance

- An estimated 1 in 5 children in Medicaid have a behavioral health diagnosis,¹ but only 1 in 10 receive services.²
- States must meet obligations under the Americans with Disabilities Act and Medicaid’s EPSDT.
- Home- and community-based services are efficacious and cost-effective.

Changes in the Number of Children Receiving Psychotropic Medications 2005 – 2011

1,686,387
2005

9% increase from 2005-2008

1,843,734
2008

17% increase from 2008-2011

2,157,045
2011

Approximately 28% more children receiving psych meds

Changes in Psychotropic Medication Expenditures, 2005 – 2011

- 2005: $1,602,793,310
- 2008: $2,202,732,411
- 2011: $2,726,520,045

70% Increase from 2005 to 2011

37% increase from 2005-2008

24% increase from 2008-2011

## Changes in the Receipt of Psychotropic Medications with and without BH Services

<table>
<thead>
<tr>
<th></th>
<th>2005</th>
<th>2008</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Psych meds with services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>w/ BH Services</td>
<td>51% 857,376</td>
<td>49% 900,220</td>
<td>53% 1,134,722</td>
</tr>
<tr>
<td><strong>Psych meds only</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>w/ BH Services</td>
<td>49% 829,011</td>
<td>51% 943,514</td>
<td>47% 1,022,323</td>
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<tr>
<td><strong>Total children receiving psych meds</strong></td>
<td>1,686,387</td>
<td>1,843,734</td>
<td>2,157,045</td>
</tr>
</tbody>
</table>

Key Medicaid Findings regarding Psychotropic Medications from 2005-2011

• The number of children receiving psychotropic medications **increased**
  • Particularly among young children (0 – 5 years)

• Concurrent use of psychotropic medication **decreased** but remains an area of concern

• Children in foster care remain a vulnerable population
  • Higher rates of concurrent use of psychotropic medication and use of antipsychotics

• Expenditures for psychotropic medications **increased**
  • Driven by ADHD medications and antipsychotics
  • Remains one of the biggest drivers of behavioral health expenses

A Complex Issue

- Medications used to control difficult behaviors
- Financial incentives drive prescribing
- Aggressive/effective pharmaceutical marketing
- Need for “quick fixes”
- Insufficient access to...
  - Psychosocial interventions
  - Behavioral health specialists
- Need for better...
  - Knowledge re: appropriate psychotropic use
  - Coordination across providers and among child-serving systems
Trends in the Use of Psychiatric Medications for Children and Youth: Implications for Practice

Christopher Bellonci, M.D.
Adjunct Associate Professor,
Tufts University School of Medicine
Vice President of Policy and Practice, Chief Medical Officer,
Judge Baker Children’s Center
cbellonci@jbcc.harvard.edu

The University of Maryland Training Institutes
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Disclosures

• No Pharma conflicts of interest
• Medical Director of the National Technical Assistance Center for Children’s Behavioral Health (funded by SAMHSA)
• Sub-PI on Grant from ACF to Develop Best Practices to support LGBT Youth in Foster Care
Introduction

• Over the last decade there has been an exponential increase in the use of psychotropic medications prescribed for emotional and behavioral disorders in children, particularly preschoolers.

• Research into the effects of these medications lags behind prescribing trends.

• These trends and the lack of research to support current practice have important implications for our work with children.
Antipsychotic medications

• Use of antipsychotic medications is amongst the fastest growing class of psychiatric medications.
• Use in Medicaid-enrolled Children age 3-18 grew 62% between 2002 and 2007;
• 354,000 children in 2007 were taking a second-generation antipsychotic (SGA).
• Evidence to support this increase for most conditions remains limited.
• ADHD is the most common diagnosis (39%, Bipolar 11%, ADHD and Bipolar 12%).
• (Meredith Matone, David Rubin, Policy Lab at CHOP, 2012)
Polypharmacy

• Between 2004-2008, for youth age 6-18:
  • SGA use increased 22%;
  • 85% of the use was concurrent with another psychiatric medication;
  • Polypharmacy occurred for long periods (69-89% of annual medication days)
  • Most significant increases over time occurred in youth who had not been hospitalized, were not in foster care or on disability or had intellectual disability.
  • Meaning concurrent use of SGAs with other psych meds is increasing disproportionately among youth with less perceived comorbidity and impairment and an overall growth in off-label prescribing for whom evidence of benefit is lacking.

Variability in Prescribing Practices

• There is every indication these rates have continued or accelerated since this data was reported.

• Children in the Child Welfare system are being prescribed psychiatric medications at an even higher rate.

• Rates of antipsychotic use increased from 8.9% in 2002 to 11.8% in 2007 (range from 2.8% in HI to 21.7% in TX). (Rubin, et. al. *Children and Youth Services Review*, 34(6), 2012)

The few research studies available show rates of psychotropic medication use ranging from 13%-50% among children in foster care

Lack of Safety and Efficacy Studies of Psychotropic medications for children

- Brain continues to develop through adolescence
- Impact of adding psychoactive medications to a developing brain is unknown
- Medications that were safe for use in adults that had unanticipated side-effects for children:
  - Tetracycline > dental discoloration
  - Second-generation antipsychotics > wt gain
  - Aspirin > Reye’s syndrome
- FDA guidelines do not limit prescribing practice.
- Medications are developed privately by Pharmaceutical companies.
- FDA requires safety and efficacy studies for target population and target purpose only.
# Level of Research Support for Psychotropic Use With Children

<table>
<thead>
<tr>
<th>PROBLEM AREA</th>
<th>MEDICATION</th>
<th>SHORT-TERM EFFICACY</th>
<th>LONG-TERM EFFICACY</th>
<th>SHORT-TERM EFFECTS</th>
<th>LONG-TERM EFFECTS</th>
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<tbody>
<tr>
<td>Anxiety Disorders (including OCD*)</td>
<td>SSRIs (*FDA indications for OCD only)</td>
<td>A</td>
<td>B</td>
<td>A</td>
<td>B</td>
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<tr>
<td></td>
<td>Benzodiazepines</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
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<tr>
<td>ADHD</td>
<td>Stimulants*</td>
<td>A</td>
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<tr>
<td></td>
<td>Atomoxetine*</td>
<td>A</td>
<td>B</td>
<td>A</td>
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<td></td>
<td>TCAs</td>
<td>A</td>
<td>C</td>
<td>A</td>
<td>B</td>
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<tr>
<td></td>
<td>Alpha-2 Adrenergic Agonists*</td>
<td>A</td>
<td>B</td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>Aggression in Autism</td>
<td>Atypical antipsychotics* (risperidone, aripiprazole)</td>
<td>A</td>
<td>B</td>
<td>A</td>
<td>B</td>
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<tr>
<td>Aggressive Conduct</td>
<td>Lithium</td>
<td>B</td>
<td>C</td>
<td>B</td>
<td>C</td>
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<tr>
<td></td>
<td>Valproate</td>
<td>B</td>
<td>C</td>
<td>A</td>
<td>A</td>
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<tr>
<td></td>
<td>Carbamazepine</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
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<tr>
<td></td>
<td>Atypical antipsychotics</td>
<td>A</td>
<td>B</td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>Lithium</td>
<td>B</td>
<td>C</td>
<td>B</td>
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<td></td>
<td>Valproate</td>
<td>C</td>
<td>C</td>
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<td></td>
<td>Carbamazepine</td>
<td>C</td>
<td>C</td>
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<td>C</td>
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<tr>
<td></td>
<td>Atypical antipsychotics*</td>
<td>A</td>
<td>C</td>
<td>A</td>
<td>B</td>
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<tr>
<td>Depression</td>
<td>SSRIs* (fluoxetine, escitalopram)</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td></td>
<td>TCAs</td>
<td>C</td>
<td>C</td>
<td>B</td>
<td>B</td>
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<tr>
<td></td>
<td>Buproprion</td>
<td>B</td>
<td>C</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>Venlafaxine</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Schizophrenia (psychosis)</td>
<td>Antipsychotics*</td>
<td>A</td>
<td>C</td>
<td>A</td>
<td>C</td>
</tr>
<tr>
<td>Tourette's Disorder</td>
<td>Antipsychotics* (haloperidol, pimozide)</td>
<td>A</td>
<td>C</td>
<td>C</td>
<td>B</td>
</tr>
<tr>
<td></td>
<td>Alpha-2 Adrenergic Agonists</td>
<td>B</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
</tbody>
</table>

SSRI – Selective Serotonin Reuptake Inhibitor; TCA = Tricyclic Antidepressant

This tool was developed by Peter Jensen. FDA approved medications for a given indication are marked with an asterisk.

- **A** = Adequate Support;
- **B** = Mixed Results;
- **C** = No controlled or negative evidence

Updated: November 1, 2010
Influence of Marketing Practices on Utilization

- Combined spending on print and digital media for SGAs went from $1.3 billion in 2007 to $2.4 billion in 2010 (an 85% increase in just three years).
- 98% of all advertising on SGAs went to sell Abilify and Seroquel (the same top two SGAs being sold).
- Doctors don’t believe marketing influences their treatment recommendations.
Practice Trends Impacted by Business Models

“It is important to balance the increasing market pressures for efficiency in psychiatric treatment with the need for sufficient time to thoughtfully, correctly, and adequately, assess the need for, and the response to medication treatment.” (AACAP policy statement 9/20/01)
Diagnostic Trends in the Field

• Shift to increasingly defining behavior as biologically determined.

• 4000% increase in the diagnosis of Juvenile Bipolar disorder in the 90s (Moreno, et. al. Arch. Gen. Psych 2007, 64 (9)).

• Comorbidity being seen as the norm so each symptom becomes a focus of medication intervention.
Balancing Risks and Benefits

- Risk vs. benefit analyses are critical both in terms of treatment with medication or no treatment.
- Need for full disclosure about what is known about the medication and what is not known (specific to the experience of use in children).
- Risks of under-treatment:
  - Kindling theory
  - Earlier presentation of mental illness is associated with worse prognosis.
  - Ex. Bipolar disorder – 15% mortality rate in adults compared to risks from Lithium treatment.
References


Children in Foster Care and Psychotropic Medications

Kamala Allen, MHS
Vice President and Director, Child Health Quality Center for Health Care Strategies
Children in Foster Care: A Special Needs Population

• Foster care entry rates are increasing:
  • 396,966 in 2012 to 437,465 in 2016

• Primary causes of removal:
  • Neglect (61%)
  • Parental Drug Abuse (34%)

• Case plan permanency goal:
  • Reunification with parents/primary caregiver (55%)
  • Adoption (26%)

Demographics

- **Age**
  - Mean age: 7.2 years old
  - Median age: 6.3 years old

- **Gender**
  - 52% male

- **Time in Care**
  - Mean: 19 months
  - Median: 13.9 months

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**Race/Ethnicity**

- White
- Hispanic
- American Indian/Alaskan Native
- Black/AA
- Two or more races
- Asian

What are Their Health Care Needs?

• Designated as “children with special health care needs” by the American Academy of Pediatrics.¹

• Higher likelihood of physical and behavioral health concerns than non-foster youth.²

• High-utilizers of behavioral health services and psychotropic medication.³

• High-expenditure population, driven primarily by behavioral health services use.³

Behavioral Health Service Use and Expense by Aid Category, 2011

BH Service User

- TANF: 72.1%
- SSI/Disabled: 16.8%
- Foster Care: 11.1%

BH Service Expense

- TANF: 51.2%
- SSI/Disabled: 28.1%
- Foster Care: 20.7%
Child Psychiatric Diagnoses Rates by Aid Category, 2011

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>TANF</th>
<th>Foster Care</th>
<th>SSI/Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHD</td>
<td>33.5%</td>
<td>38.0%</td>
<td>47.8%</td>
</tr>
<tr>
<td>Conduct disorder</td>
<td>31.8%</td>
<td>39.9%</td>
<td>30.4%</td>
</tr>
<tr>
<td>Mood disorder</td>
<td>30.9%</td>
<td>39.3%</td>
<td>31.4%</td>
</tr>
<tr>
<td>Anxiety disorder</td>
<td>22.5%</td>
<td>23.2%</td>
<td>15.4%</td>
</tr>
<tr>
<td>PTSD</td>
<td>5.0%</td>
<td>13.1%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Develop. Disability</td>
<td>2.9%</td>
<td>4.6%</td>
<td>16.4%</td>
</tr>
<tr>
<td>Psychosis</td>
<td>2.0%</td>
<td>3.1%</td>
<td>5.5%</td>
</tr>
<tr>
<td>SUD diagnosis</td>
<td>6.3%</td>
<td>7.7%</td>
<td>3.9%</td>
</tr>
<tr>
<td>No diagnosis</td>
<td>12.7%</td>
<td>9.1%</td>
<td>12.6%</td>
</tr>
</tbody>
</table>

**Key**
- Lowest rates
- Highest rates
# Rate of Psychotropic Medication Use by Aid Category

<table>
<thead>
<tr>
<th></th>
<th>2005</th>
<th>2008</th>
<th>2011</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>TANF</td>
<td>4.2%</td>
<td>4.2%</td>
<td>4.9%</td>
<td>+17%</td>
</tr>
<tr>
<td>Foster Care</td>
<td>23.1%</td>
<td>22.9%</td>
<td>24.4%</td>
<td>+6%</td>
</tr>
<tr>
<td>SSI/Disability</td>
<td>26.9%</td>
<td>28.5%</td>
<td>29.5%</td>
<td>+10%</td>
</tr>
</tbody>
</table>
Foster Children and Psychotropic Medications

• Of receiving psychotropic medications, those in foster care:
  • Were prescribed psychotropic Rx at a rate 6x their representation in Medicaid (TANF children at ½x)
  • Had Medicaid expenditures for psychotropic Rx at a rate 2x those of TANF children
• Of children in foster care who received psychotropic medications, concerns include:
  • 41% prescribed antipsychotics vs. 17% of TANF children
  • 18% on three or more psychotropic Rx within the year vs. 16% of the child SSI population and 6% of the child TANF population

“HHS has become increasingly concerned about the safe, appropriate, and effective use of psychotropic medications among children in foster care.”
Opportunities to Improve the Quality of Care for Children in Foster Care

• Expand access and utilization of home- and community-based services

• Expand access to psychosocial interventions

• Support the adoption of trauma-informed approaches to care

• Establish data-sharing agreements among health care and child-serving agencies to closely monitor use of psychotropic medications – including antipsychotics – and enforce prescribing guidelines
Psychotropic Medicaid Quality Improvement Collaborative

• Annie E. Casey Foundation-funded initiative
• 3-year learning collaborative of six states (IL, NJ, NY, OR, RI, VT)
• Goal: Improve appropriate use of psychotropic medication use for children in foster care
• Objective: Strengthen psychotropic medication oversight and monitoring specifically for the foster care population
  • Improve consent processes
  • Educate/train primary care providers, case workers and families/youth
  • Increase access to/use of psychosocial interventions
  • Reduce inappropriate use of psychotropic medications, with a focus on antipsychotics and use among very young children
PMQIC Highlights

• Illinois
  • Wrote and published Policy 325.4 for obtaining an evidence-informed assessment and psychosocial services for preschool-aged children with emotional and behavioral problems, and designed DCFS trainings.
  • Devised and distributed guidelines on psychotropic medications for children under age 5.
  • **Highlighted Impact:** Greater use of psychosocial interventions for children under age 5 and prescribers are following recommended prescribing guidelines > 66% of the time.

• New Jersey
  • Assigned a nurse to all children in custody on psychotropic medications
  • Trained nurses on psychotropic medication oversight, treatment planning and quality assurance process for monitoring clinical progress
  • Focus on children under age 6
  • **Highlighted Impact:** Increase in inclusion of psychosocial interventions in treatment plans
PMQIC Highlights

• Oregon
  • Launched a statewide telephonic psychiatric access program
  • Created a Psychotropic Medication Stakeholder Advisory Committee
  • Created training to support less reliance on psychotropic medications
  • Improved the consent process and implemented a shared decision-making model
  • **Highlighted Impact**: Appreciable decrease in AP prescribing

• Vermont
  • Implemented oversight policy for children and youth already on antipsychotic medications.
  • Contracted with the University of Vermont Department of Child Psychiatry to provide consultation services
  • Implemented a DVHA Pharmacy Tool that provides all Medicaid prescription history
  • **Highlighted Impact**: Decrease in antipsychotic medication use from 22.51% to 16.26% over 3-year period.
Funding Oversight and Monitoring

- Legislative Mandates
  - Illinois
  - Oregon

- Agency contracts with clinicians
  - New Jersey
  - Rhode Island
Prior Authorization Programs

Issue brief includes descriptive overviews of 14 of 31 programs:

- California
- Florida
- Georgia
- Illinois
- Pennsylvania
- Maryland
- Massachusetts
- Minnesota
- Nevada
- New York
- North Carolina
- Texas
- Virginia
- West Virginia
- Wisconsin
Resources

• Faces of Medicaid Child Behavioral Health Analyses:

• CHCS Online Resource Center:

• Slides from PMQIC National Webinar:
  • [https://www.chcs.org/media/PMQIC-National-Webinar-1.pdf](https://www.chcs.org/media/PMQIC-National-Webinar-1.pdf)
Building a Psychiatric Consultation Program: Lessons from Massachusetts and Beyond

John Straus, MD

MCPAP funded by Massachusetts Department of Mental Health

July 27, 2018
Goals for Today

• Discuss Vision for MCPAP

• Describe how MCPAP works and the results
  • Preliminary pharmacy data using state APCD

• Provide national update on Child Psychiatry Access Programs (CPAPs)
Studies indicate that 40% of all psychiatrists only accept self-paying patients.
Support pediatric PCPs (Pediatricians and Family Physicians) to:

- Manage MH/SUD appropriate for primary care
- Screen and manage youth with common conditions:
  - ADHD
  - Depression
  - Anxiety Disorders
  - Substance Use Disorders
- Understand, connect, refer to the community BH system
- Use standardized BH screening tools
- Provide population based access – blind to insurance
- Provide real time help
MCPAP’s Evolved Vision

- Support integration of BH into primary care
- Support Co-located behavioral health clinicians
- Support collaborative care model to achieve good outcomes (Impact Model)
  - Advice evidence based
  - Support all members of team
  - Reinforce tracking of youth with BH issues
  - Reinforce treating to measured outcomes
  - Advice cost effective
  - MCPAP consultation provided within framework of model (case rounds)
- Provide support to complex youth, especially in rural areas (bridging)
MCPAP’S Ongoing Goals

To improve the pediatric team’s competencies in:

- Screening, identification, and assessment
- Treating mild to moderate BH conditions
- Making effective referrals for community services
- Advocating for the care of more complex patients who need specialty psychiatric and behavioral health services
3 teams cover the state – 1,500,000 youth

Boston South
Boston Children’s Hospital
Tufts Medical Center
McLean Southeast

Boston North
Mass General Hospital
North Shore Medical Center

West/Central
Baystate Medical Center
UMass Memorial Medical Center

Each team:
2 FTE child psychiatrist
1 FTE behavioral health clinician
1 FTE resource & referral specialist
1 FTE program coordinator
Enrollment

MCPAP enrolls PCP Practices in order to facilitate their engagement by:

• Understanding operation of the program
• Knowledge of each other – personal connection
• Collecting of demographics
MCPAP Services

- Telephone Consultation
- Face to Face Consultation
- Resource and Referral
- Training and Education
Telephone Consultation

PCP or BH Clinician calls MCPAP Team with question and reaches Program Coordinator.

Program Coordinator pages psychiatrist or BH Clinician. Caller receives return call within maximum of 30 minutes.

Caller receives answer to question; recommendation for face-to-face appointment; and/or recommendation for resource and referral.
Face-to-Face Assessment

- May consist of:
  - Diagnostic Question
  - Medication Question
  - Second Opinion
  - Reassure PCP

- Followed by a consult letter within 48 Hours
Resource and Referral

• Community services can include:
  • Psychiatry
  • Psychotherapy
  • Child home and wraparound services
  • Neuropsychological testing
  • Support groups, group therapy, social skills groups, parent education, early intervention

• MCPAP maintains statewide database of resources
Training and Education

Training on-site at practices and via webinar and videoconference on:

- Screening and toolkits – SUD (S2BI)
- Clinical topics
- Resources and the mental health system
- Clinical guidelines and registries
- Information on practice transformation to integrate behavioral health
- Topics for case rounds
- Topics for monthly Clinical Conversation webinars
Keys to PCP Engagement

- Be helpful on every call
- Mentor
- Personalized, local
- Resource and Referral
- Tailored Education
- No system required tasks for PCPs
Additional MCPAP Services

www.mcpap.org

What About the Siblings?

By Emily Rubin

While the struggles of children with mental health or behavioral health conditions are well known, the stress on their well siblings is often overlooked.

“In most families I’ve worked with, the child with mental health issues gets most of the attention. Parents try their hardest to pay attention to siblings but they are overwhelmed,” says Emily Rubin, director of Sibling Support, Eunice Kennedy Shriver Center and Lecturer, Department of Psychiatry, University of Massachusetts Medical School.

Continued on page 2
Current Funding for MCPAP

- Budget set by annually by legislature as part of Department of Mental Health appropriation

- All insurers (both Medicaid and Commercial) pay their share proportional to their utilization of program

- Share for each commercial insurer based on their outpatient spending as reported annually to Division of Insurance similar to formula for state purchasing of child vaccines
MCPAP Results: Use and Cost

• Over 95% of pediatric PCPs enrolled (463 practices, 3,026 providers)
• 63% of primary care pediatricians used service in FY16
• Utilization in FY17:
  • 80% well child visits with standardized behavioral health screen
  • 6,027 children served
  • 7,346 phone consults
  • 1,949 consult visits
  • 3,263 referrals arranged
• Prescriber level care remains with PCP 68% of episodes, no psychiatrist needed
• $2.33 per child per year
• Commercial insurers pay their share (56%)
MCPAP Results: PCP Knowledge

- PCPs reported comfort treating:
  - ADHD – 77%
  - Depression – 68%
  - Anxiety – 67%
  - SUD – 15% (SIM grant support to increase SUD competence.)
MCPAP Results: PCP Satisfaction

Mean MCPAP Satisfaction Survey Responses

- Consults are useful
- Able to receive child psychiatry consult in timely manner
- Usually able to meet needs of children with psychiatric problems
- Adequate access to child psychiatry for my patients

#LEADINGCHANGE

Massachusetts Child Psychiatry Access Program
MCPAP - Prescribing

• Analysis of state All Payer Claims Database (APCD)
  • Data over 5 years (2010 thru 2014)
  • Covers about 93% of youth with insurance claims per year
    ▪ 1.5 million youth in state
  • 95% of youth with primary care claim in MCPAP-enrolled practice
### Percentage of Youth Prescribed Psychotropic by Insurer

<table>
<thead>
<tr>
<th>Medication</th>
<th>Payer</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stimulant</td>
<td>Medicaid</td>
<td>4.2%</td>
<td>4.1%</td>
<td>4.0%</td>
<td>4.0%</td>
<td>4.0%</td>
<td>-4.8%</td>
</tr>
<tr>
<td></td>
<td>Commercial</td>
<td>3.2%</td>
<td>3.3%</td>
<td>3.5%</td>
<td>3.5%</td>
<td>3.2%</td>
<td>0.0%</td>
</tr>
<tr>
<td>SSRI/SNRI</td>
<td>Medicaid</td>
<td>2.03%</td>
<td>2.02%</td>
<td>2.06%</td>
<td>2.15%</td>
<td>2.27%</td>
<td>11.8%</td>
</tr>
<tr>
<td></td>
<td>Commercial</td>
<td>1.86%</td>
<td>2.02%</td>
<td>2.19%</td>
<td>2.37%</td>
<td>2.39%</td>
<td>28.5%</td>
</tr>
<tr>
<td>Antipsychotic</td>
<td>Medicaid</td>
<td>2.20%</td>
<td>2.00%</td>
<td>1.83%</td>
<td>1.77%</td>
<td>1.65%</td>
<td>-25.0%</td>
</tr>
<tr>
<td></td>
<td>Commercial</td>
<td>0.74%</td>
<td>0.72%</td>
<td>0.69%</td>
<td>0.66%</td>
<td>0.57%</td>
<td>-23.0%</td>
</tr>
</tbody>
</table>
## Percentage of Psychotropics Prescribed by PCP

<table>
<thead>
<tr>
<th>Medication</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stimulant</td>
<td>74.0%</td>
<td>74.8%</td>
<td>75.4%</td>
<td>77.0%</td>
<td>77.8%</td>
<td>10.5%</td>
</tr>
<tr>
<td>SSRI/SNRI</td>
<td>47.5%</td>
<td>49.2%</td>
<td>51.8%</td>
<td>55.2%</td>
<td>57.0%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Antipsychotic</td>
<td>38.6%</td>
<td>40.2%</td>
<td>41.7%</td>
<td>44.7%</td>
<td>43.9%</td>
<td>13.7%</td>
</tr>
</tbody>
</table>
Association between MCPAP Utilization and Children Prescribed Stimulants by PCP (2014)

- Practices with more frequent utilization of MCPAP prescribed stimulants more frequently in primary care than practices with less frequent MCPAP utilization.

One way ANOVA, F=7.717, p<.0001

MCPAP utilization categories: 0=No Utilization/year, 1=Used MCPAP 1-3 times/year, 2= Used MCPAP 4-17 times/year and 3= Used MCPAP 18 times or more/year
MCPAP – an idea that has caught on!

National Network of Child Psychiatry Programs (NNCPAP.org)

Alaska
Arkansas
*California
*Colorado
Connecticut
*Delaware
Florida
Georgia
Illinois
*Iowa
*Maine

Maryland
Massachusetts
*Michigan
Minnesota
*Mississippi
*Missouri
Nebraska
*New Hampshire
New Jersey
New York
*North Carolina

Ohio
Oregon
Pennsylvania
Rhode Island
Texas
*Vermont
*Virginia
Washington
Washington, DC
*Wisconsin
Wyoming

Over a third of all children in US covered – 24 million.

*Partial state, Red = Developing
How to Create CPAP in Your State?

• Child Mental Health Task Force of Stakeholders
• Pilot
• Suggest Legislative Path
Funding Mechanisms

- State Funding
- Pennsylvania Medicaid Model
  - Medicaid capitation to physical health plans increased in proportion to their child population and plans jointly contract with vendors to provide consultation service.
- Insurance surcharge by state to cover cost of program.
- Direct Medicaid funding – DYSRP funds
- Health plans agree to split up cost
- Grant funding – 21st Century Cures Act ($10M)

HRSA RFP!
Variations on MCPAP Model

- Include standard didactic component at enrollment
- Include learning collaborative – Project Echo/REACH PPP
- Standard algorithms
- Pre-consult form completed by PCP
- Rotate child psychiatrist between group of practices
- Include regional behavioral health clinicians
- Add psychotropics medication review, prior approval
MCPAP Expansion to MCPAP for Moms

• Started 7/1/14
• Postpartum depression, perinatal mental health and SUD
• Assisted over 4,000 women
• www.mcpapformoms.org
Contact

John H. Straus, M.D.
Massachusetts Behavioral Health Partnership
Beacon Health Options
1000 Washington Street, Suite 310
Boston, MA 02118
John.Straus@beaconhealthoptions
617-790-4120
MCPAP References


Time for a paradigm shift?

• The Outcomes Roundtable for Children and Families (ORCF) funded by SAMHSA—a consortium of researchers, youth, family members, providers, and policymakers.

• Core outcomes are that children are “at home, in school and out of trouble”—outcomes that are no different for parents whose children experience mental illness.
Lifetime Outcomes

• To be **happy**; the internal experience of being free from anxiety or depression

• To live **at home**, with their family and in their community

• The **capacities** for self-empowerment, self-control, self-acceptance, self-awareness, self-efficacy, self-advocacy, self-esteem, and ultimately to feel in control of one’s life

• **Success in school** or work

• To **have fun** and be able to engage and enjoy community activities, including sports and play
Lifetime Outcomes

- To feel and be safe
- To stay out of trouble
- To be sober and/or not abusing substances
- To have meaning and purpose in their lives (spirituality, altruism)
- To develop healthy and positive interpersonal skills that support meaningful relationships, sexuality, fitting in, having friends, and a natural support system
- To experience positive physical health and to receive the healthcare needed to treat physical illness
Community and Social Supports

Training, education, capacity and skill building

Services ultimately must support skill development.

Goals

Functional Life Domains

Self- and somatic regulation
Social skills
Executive functions
Emotional regulation
Self-monitoring
Communication skills
School and work readiness
Other

Happiness
In family/at home
Self-empowerment
Success in school/work
Have fun
Feel and be safe
Out of trouble
Sober/Drug Free
Have meaning/purpose
Interpersonal
Physical health

Developmental Competencies

Treatment

Treatment of the child and family aids in the acquisition of some developmental competencies such as emotional regulation.

Training, education, capacity and skill building

Capacity and skill building needed to develop many of the developmental competencies.
Relationship to Evidence-based Treatments (EBT’s)

• Various meta-analyses (Chorpita & Daleiden, 2010) help to distinguish the **common elements** that occur across families of related interventions (e.g., cognitive behavioral therapies, caregiver-administered behavioral interventions, interpersonal therapies).

• At the heart of most therapies is the teaching of, and support for, **skills acquisition** necessary to return to normal development.
Teaching skills to promote resilience

• Interventions that enhance skills underlying developmental competencies help build “virtuous cycles” (Masten & Coatsworth, 1998).

• Enhanced skills promote greater competency, boosting a developing sense of self, which serves as the basis for confidence in continued success and expanded spheres of application, producing characteristic hallmarks of resilience.
• A public health prevention and resiliency focus in the provision of children’s mental health services and supports is in keeping with major national policy directions, as well as evidence-based practice.

• Evidenced-based practices that focus on helping parents learn how to help their children develop these competencies will help prevent later deficits in day-to-day functioning.
IMPLICATIONS FOR POLICY AND PRACTICE

• Approaches that are strengths based and strengths building are proving to be the most effective in working with children and adolescents.

• It does, however, imply a reshaping of practice to interventions designed to create the conditions in the family and community under which the child can move forward developmentally and acquire the competencies for a successful life.
IMPLICATIONS FOR POLICY AND PRACTICE

• Historically, **policy and funding have been focused on remediation of deficits.**

• Institutionalizing policy expectations that services and supports focus on strengths-based approaches that promote healthy families and skill development for children will lead to changes in funding priorities and practice **consistent with Systems Of Care approaches and values.**
Systems of Care Approaches

• Ensuring these evidence based interventions are available in the service array and accessible

• **Workforce development** (training, coaching, supervision, certificate programs)

• **Fiscal issues** (e.g. incentives for implementing EBPs, $ for training and ongoing professional development) need attention in the system to ensure providers to whom youth may be referred are capable of implementing the most effective programs for depressive disorders... esp in light of the 10-15% prevalence rate in adolescents
Systems of Care Approaches (cont’d)

• Ensuring that care coordinators / wrap facilitators are aware of the need to access relevant EBPs when planning with a youth/family/team, and know who provide such treatments

• Building capacity for peer to peer support in a system and service array so that there are other relevant supports readily available
IMPLICATIONS FOR POLICY AND PRACTICE

• Reshaping children’s mental health practice will require extensive workforce development.

• This ideally will begin in the institutions of higher learning with revision of their core curricula across disciplines.

• A push for evidence-supported work and outcomes in policy will need to be accompanied by resources for technical assistance and training.
QUESTIONS?