Medications in School Mental Health: When all you have is a hammer, does everything look like a nail?

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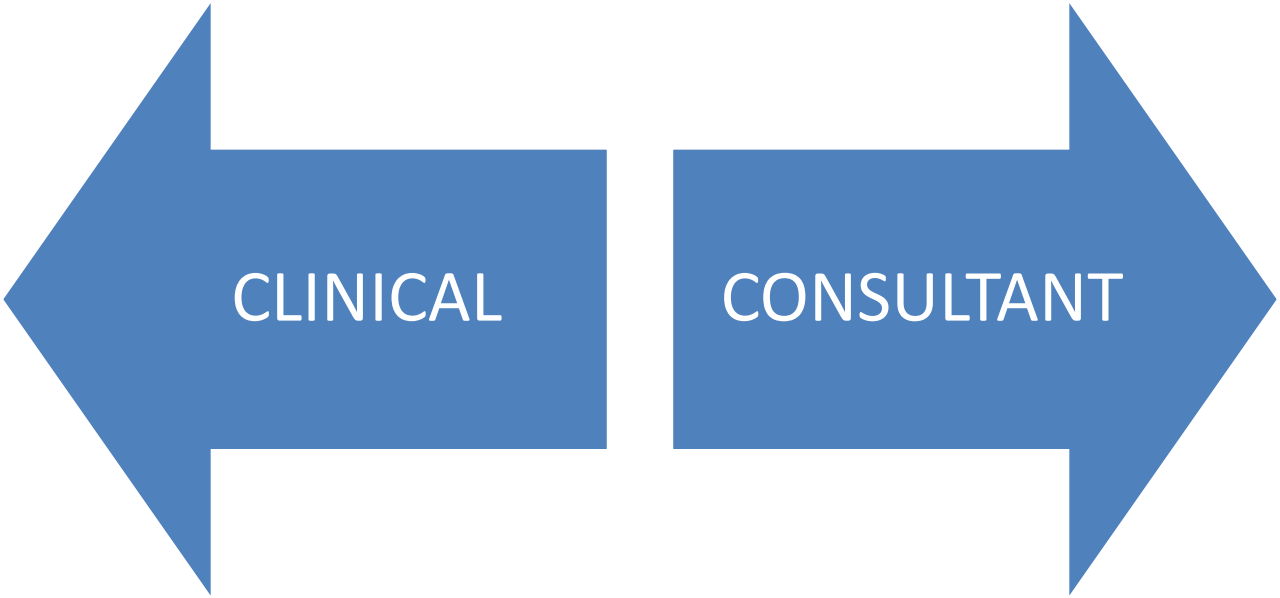
At the end of this session, participants will be able to:

- identify practical and ethical considerations of psychiatric medication management in schools, including potential negative consequences of prescribing in this setting.

- describe the role for psychiatrists and psychiatric advanced practice nurses who prescribe medications in schools and describe how telehealth services may enhance care for students with psychiatric conditions.

- discuss the potential benefit of strategies that broaden the school psychiatry consultant role beyond medication management.

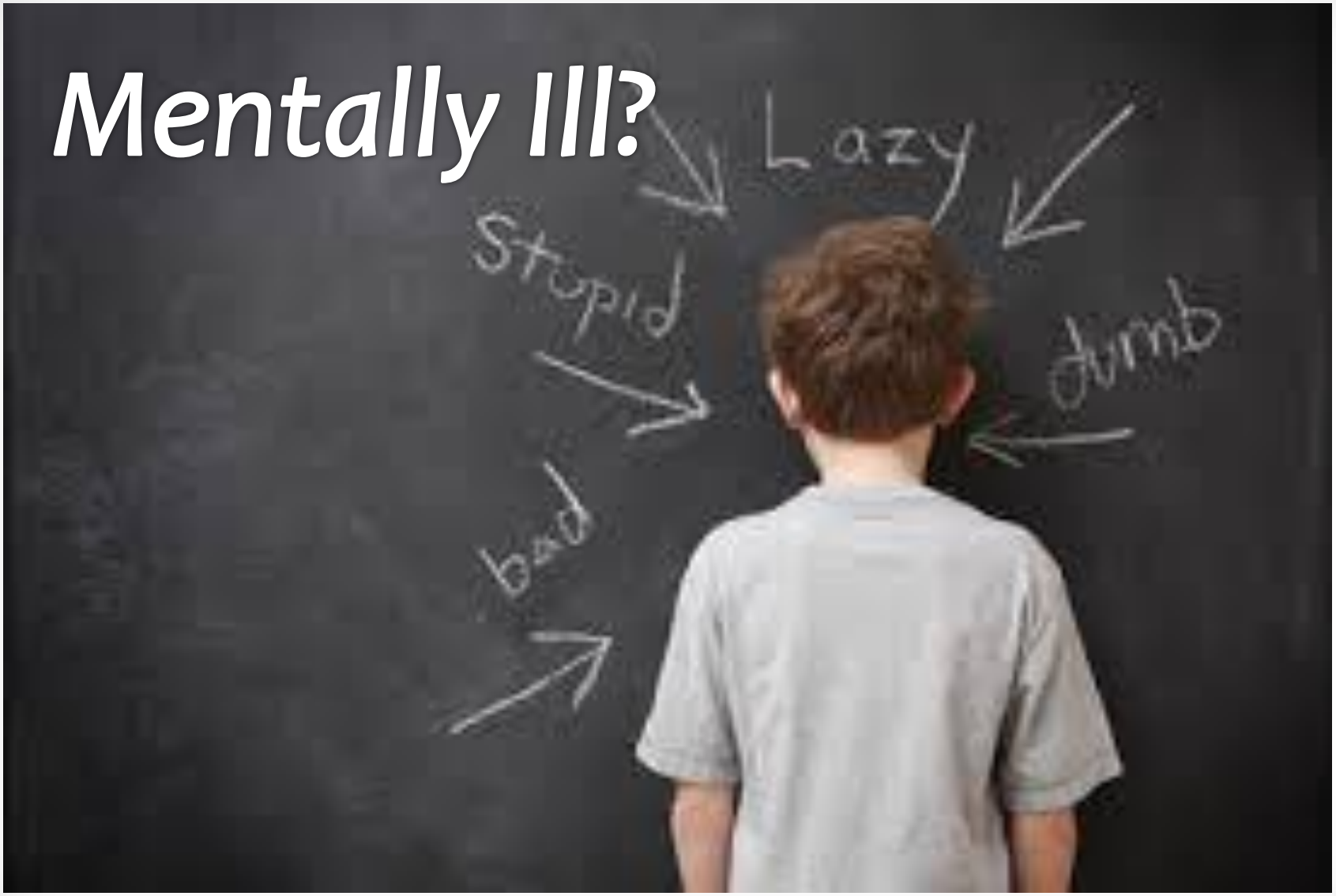
Child psychiatrist role in schools



Most important task for child psychiatrist in schools…

Most important task for child psychiatrist in schools…

to help adults see the *difficult child* in a new way.


Mentally Ill?
Lazy
Stupid
dumb
bad

Use of prescribed medication during the past 6 months for emotional or behavioral difficulties varied by sex, age, and race and Hispanic origin among children aged 6–17 years.

Figure 1. Percentage of children aged 6–17 years prescribed medication during the past 6 months for emotional or behavioral difficulties, by sex and age group, and race and Hispanic origin: United States, 2011–2012

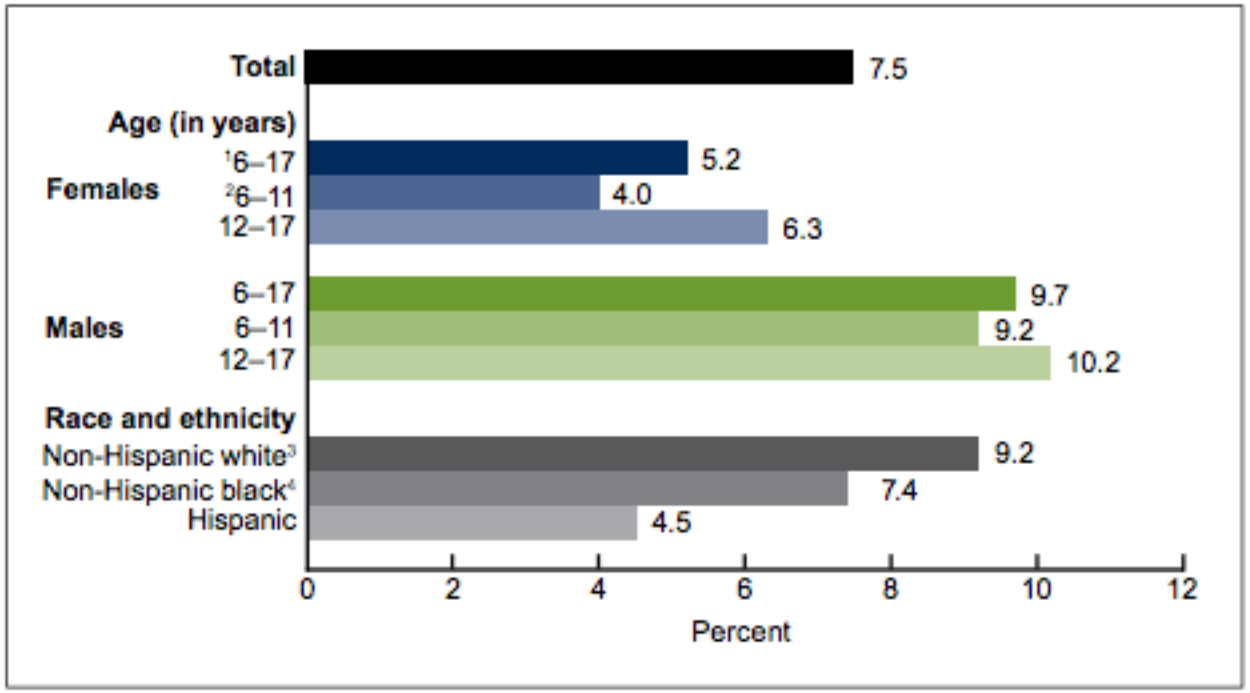


Figure 2. Percentage of children aged 6–17 years prescribed medication during the past 6 months for emotional or behavioral difficulties, by health insurance status: United States, 2011–2012

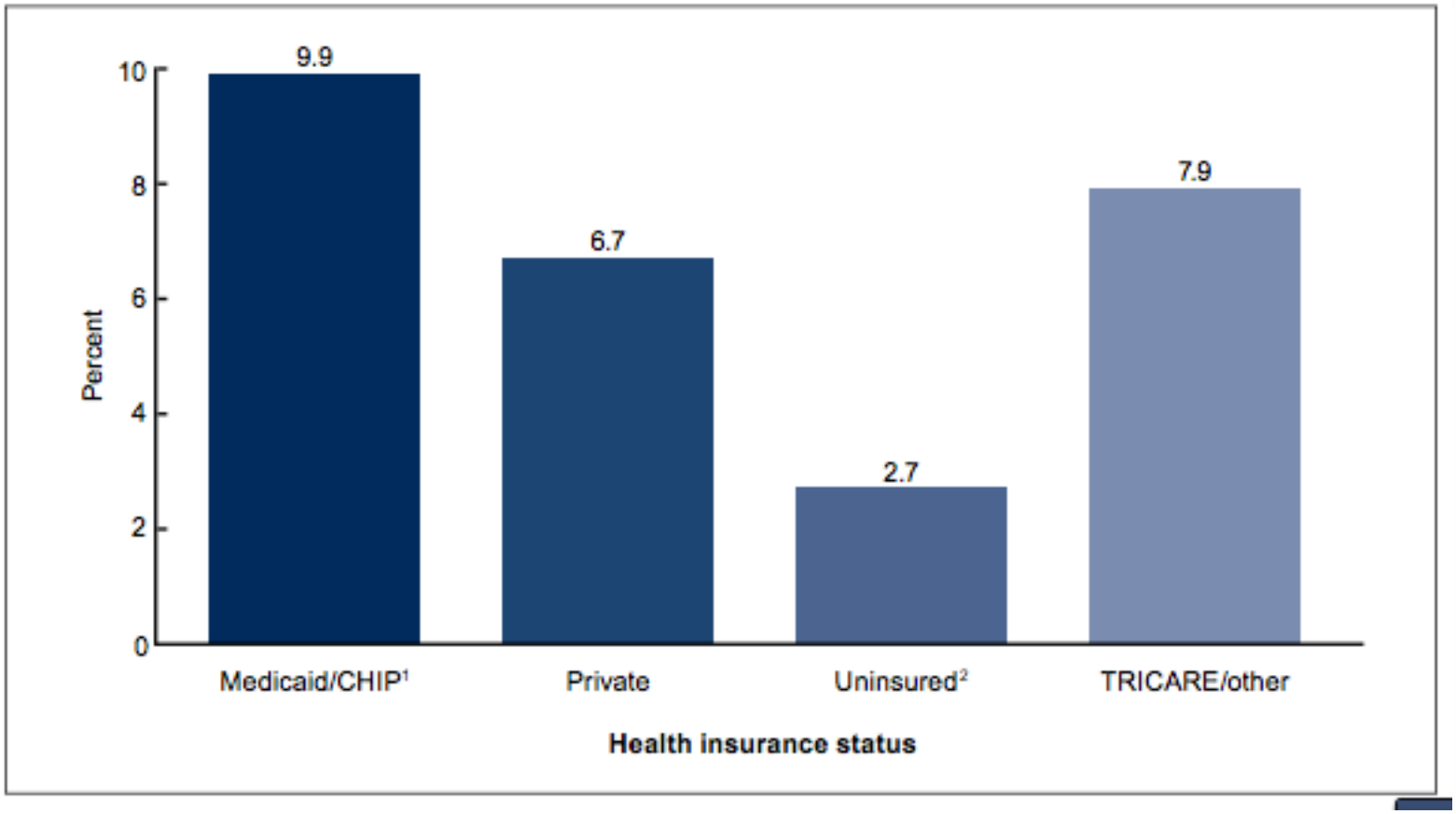


Figure 3. Percentage of children aged 6–17 years prescribed medication during the past 6 months for emotional or behavioral difficulties, by poverty status: United States, 2011–2012

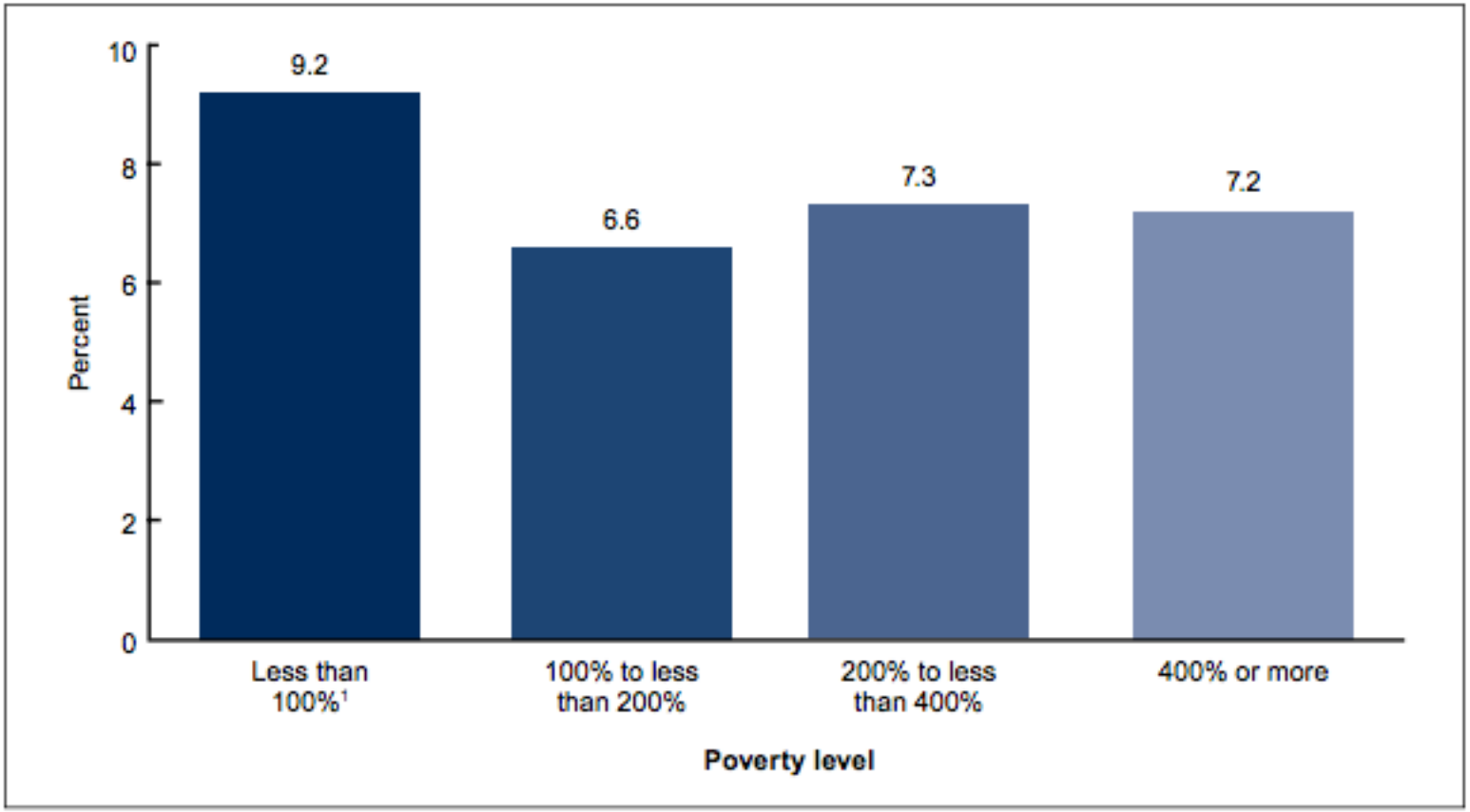
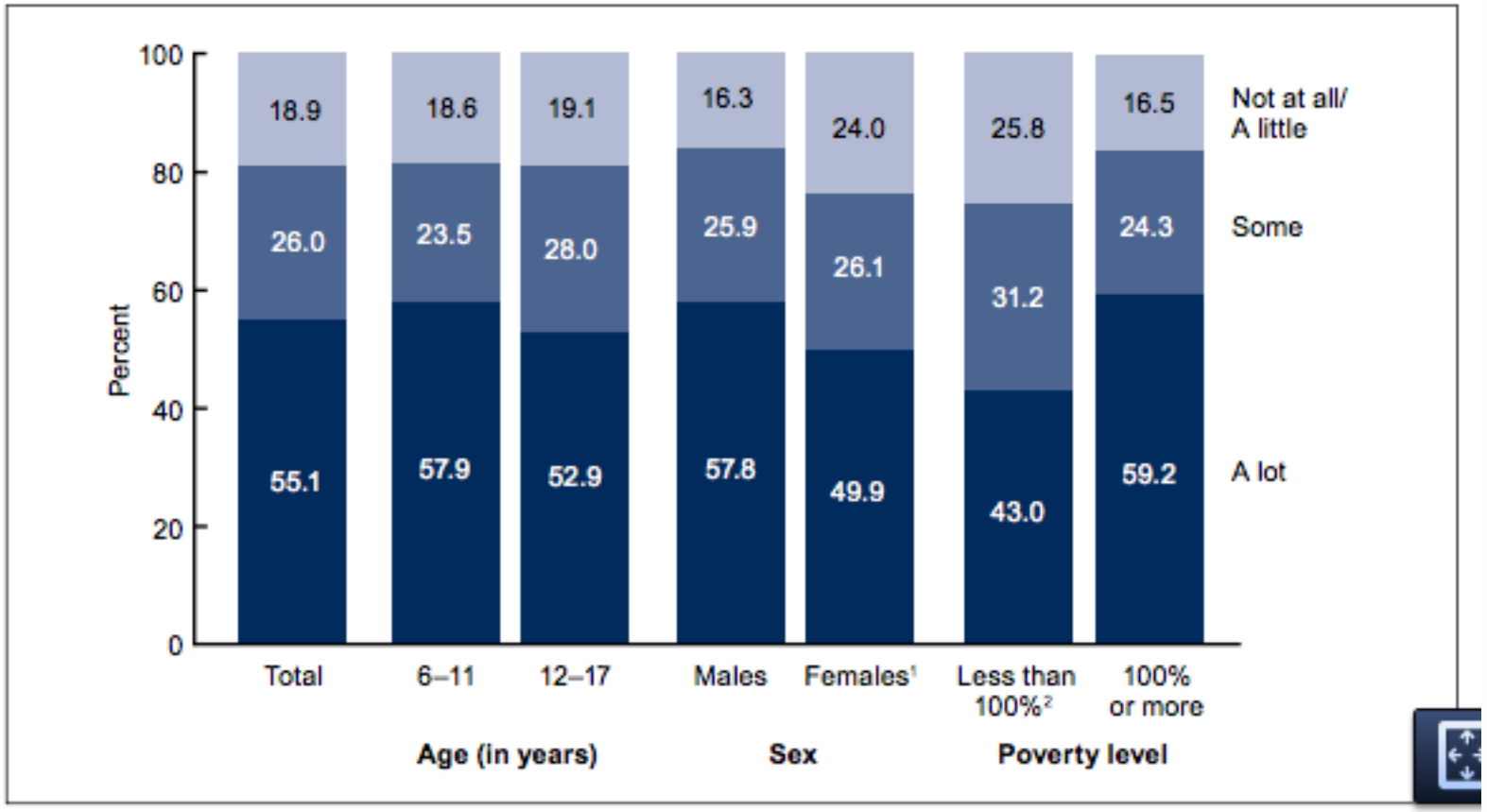


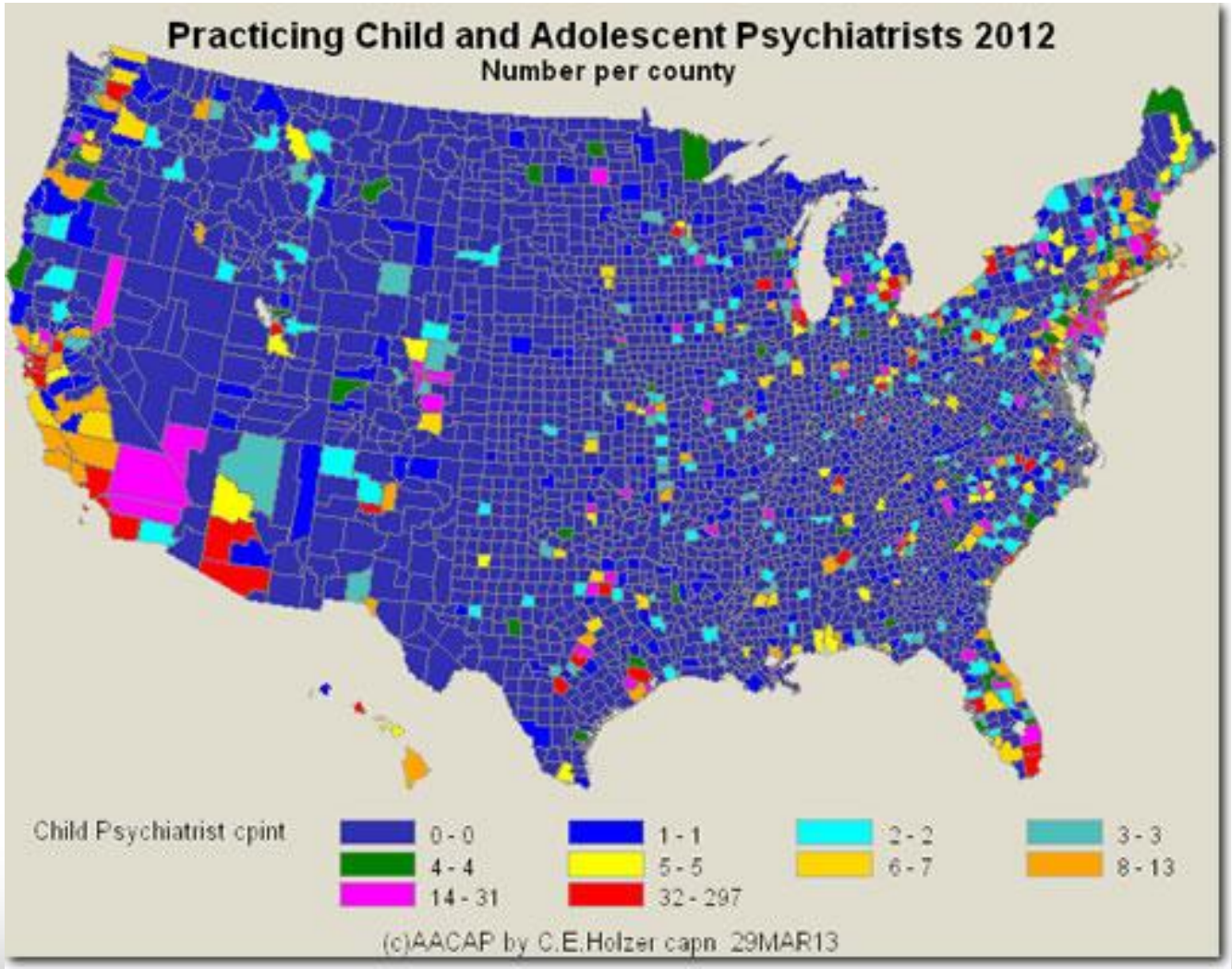
Figure 4. Percentage of children whose parents reported perceived benefit of medication for emotional or behavioral difficulties by age group, sex, and poverty status among children aged 6–17 years prescribed medication during the past 6 months: United States, 2011–2012



Most important task for child psychiatrist in schools…

empower the team to solve problems and mobilize systems.

Child psychiatrists in US: ~8500



Models of consultation
Handbook of School Mental Health

- Ad hoc
- Informal
- Organized School Mental Health System
- Formal and contractual relationship
- Systems

Potential benefits of the consultant role

- greater impact on larger number of students
- ability to affect systems level change
- incorporate broad skills
- referral to community providers

Potential barriers to the consultant role

- culture
- lack of resources for outside referral
- narrow definition for CAP
- pressure to “fix it”
- trainee discomfort with expert role
- vague notion of consultation questions

Potential benefits of the clinical role

- greater impact on individual student
- compared to office-based practice:
  - greater access to patients
  - greater appreciation of symptoms
- provide for unmet need
- educate system through collaboration

Ethical considerations

Critical consultation questions

- Who is the consultee?
  - patient and family?
  - collaborating clinician?
  - school?
- What is the question?

Best practices when assuming a clinical role

- Collaboration with other clinicians
- Collaboration with school staff
- Respecting boundaries

Effective collaboration with prescribers

- Schedule time to review progress
- Access to school data
  - psychoed testing
  - attendance; discipline; grades
- Be specific about concerns

  "the meds aren't working"

  versus

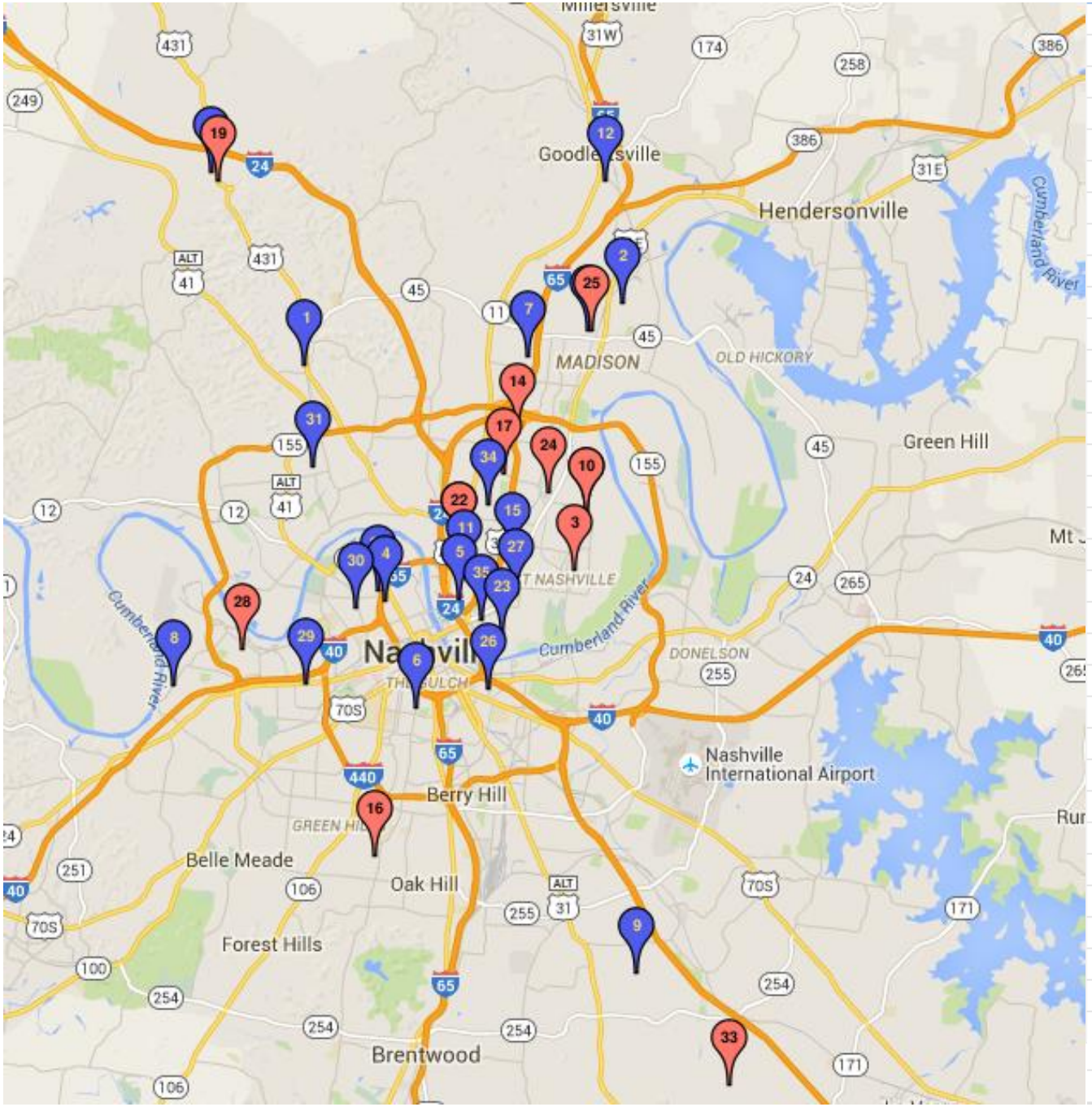
  "more disruptive after lunch"

Effective collaboration with prescribers

- Share data
  - log behavior
  - what have you tried
  - what worked; what didn't
- Get parents involved


METROPOLITAN NASHVILLE
STOP

Vanderbilt School Based Mental Health Program



1 Alex Green Elementary School
2 Amqui Elementary School
3 Bailey Middle School
4 Buena Vista Elementary School
5 Caldwell Elementary School
6 Carter Lawrence Elementary
7 Chadwell Elementary School
8 Charlotte Park Elementary School
9 Cole Elementary School
10 East End Prep Middle School
11 Glenn Elementary School
12 Goodlettsville Elementary School
13 Goodlettsville Middle School
14 Gra-Mar Middle School
15 Hattie Cotton Elementary School
16 J.T. Moore Middle School
17 Jere Baxter Middle School
18 Joelton Elementary School
19 Joelton Middle School
20 Jones Paidea Elementary School
21 Kipp Academy Middle School
22 Kipp College Prep Middle School
23 Kirkpatrick Elementary School
24 Liberty Middle School
25 Madison Middle School
26 Napier Elementary School
27 Nashville Classical Elementary School
28 Nashville Prep Middle School
29 Park Avenue Elementary School
30 Robert Churchwell Elementary School
31 Robert E. Lillard Elementary School
32 Stratton Elementary School
33 Thurgood Marshall Middle School
34 Tom Joy Elementary School
35 Warner Elementary School

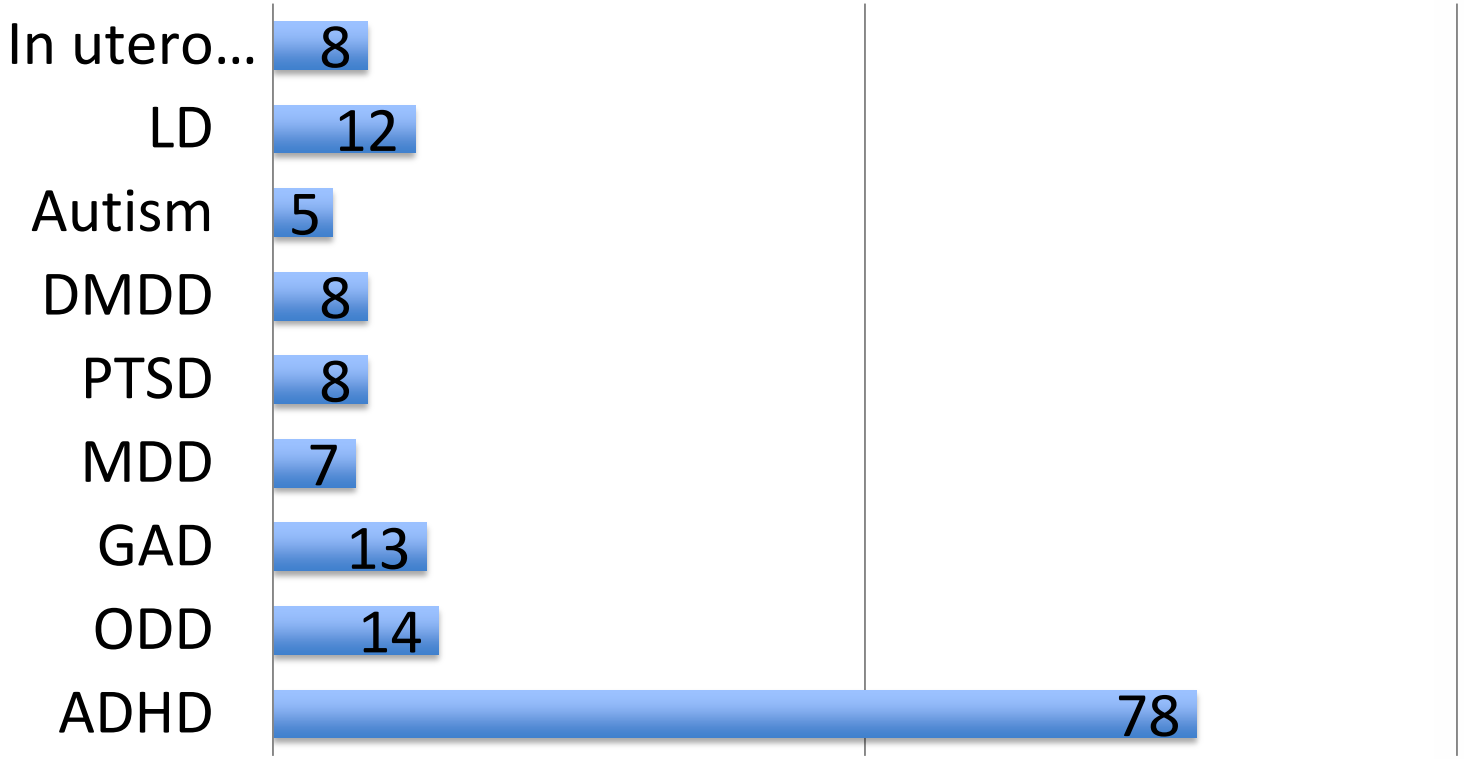
Vanderbilt School Mental Health Program Staffing

- 30 masters level clinicians
- Medical director (0.1 FTE)
- 3-4 CAP fellows ½ day per week
- Nurse practitioner (0.75 FTE)

Services Offered

- individual, group and family therapy
- medication management
- crisis management
- classroom/teacher consultation
- IEP and support team consultation
- collaboration with other service providers

Current NP caseload



Roles of the collaborating psychiatrist

- clarify diagnoses
- plan effective treatment
- consider the need for medication
- prescribe and monitor medication
- consult with the clinician on complex cases

UNIVERSITY of MARYLAND
SCHOOL OF MEDICINE

University of Maryland School Mental Health Program: Psychiatry and Telepsychiatry in Schools

Jennifer Cox, LCSW-C

Division of Child and Adolescent Psychiatry

University of Maryland School of Medicine

November 5, 2015

CSMH
Center for School Mental Health

University of Maryland
School Mental Health Program (SMHP)

Executive Director: Nancy Lever
Senior Advisor: Sharon Stephan
Program Director: Michael Green
Associate Director: Jennifer Cox
Assistant Director: Kelly Willis

- Established 1989 in 4 schools
  - Currently in 27 schools (33 including partnership with Villa/Catholic Charities)
- Elementary through high school
- Mental health promotion, prevention, intervention
- Predominantly serving students in general education
- Low SES, highly stressed communities, violence exposure, substance abuse
- Licensed social workers, psychologists, counselors, psychiatrists, and graduate trainees

History

- In 1989, The University of Maryland School Mental Health Program began providing mental health services in four Baltimore city Schools.
- Baltimore was one of the first cities to develop School-based health centers and has become the leader in the development of school-based health centers.

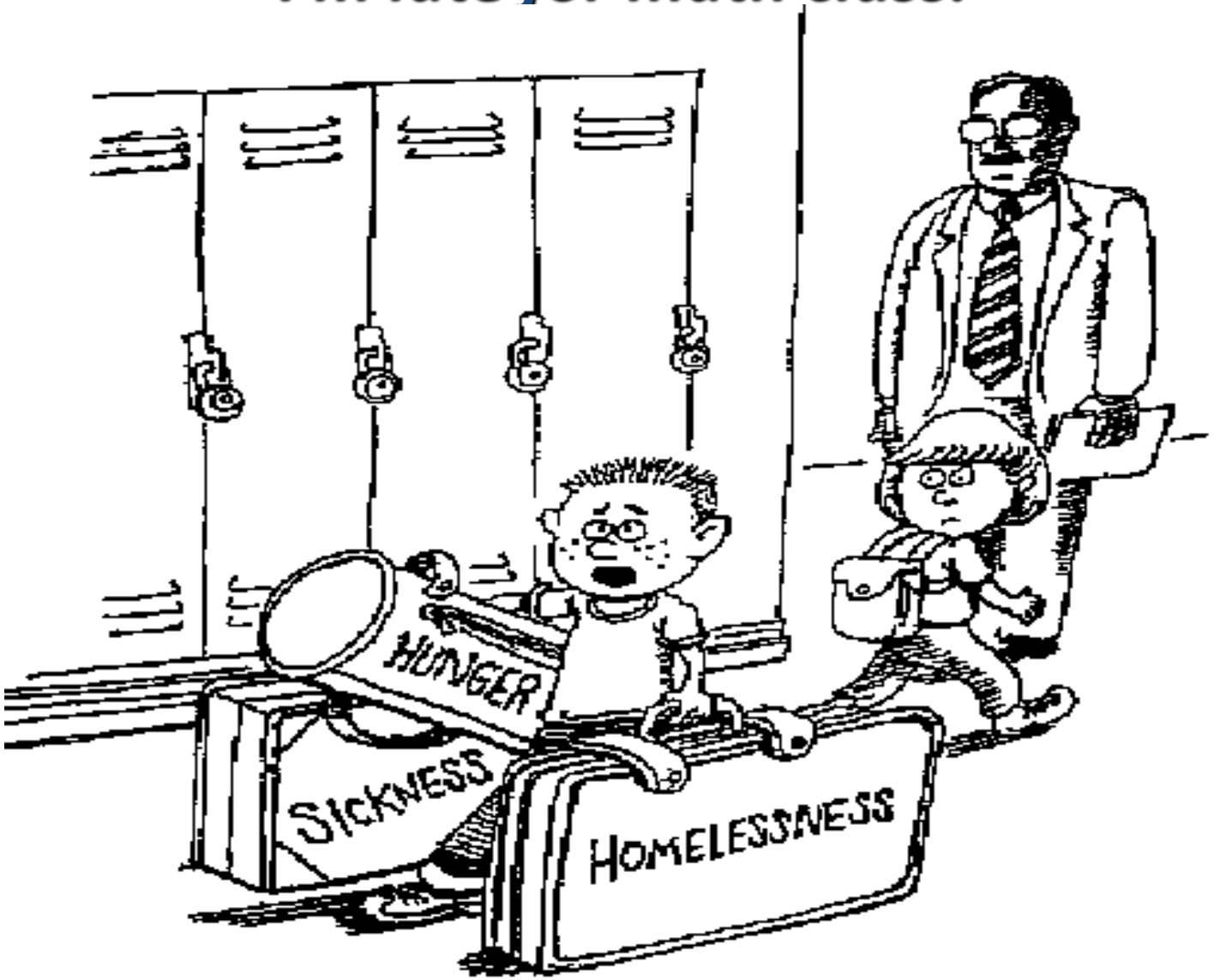
What We do

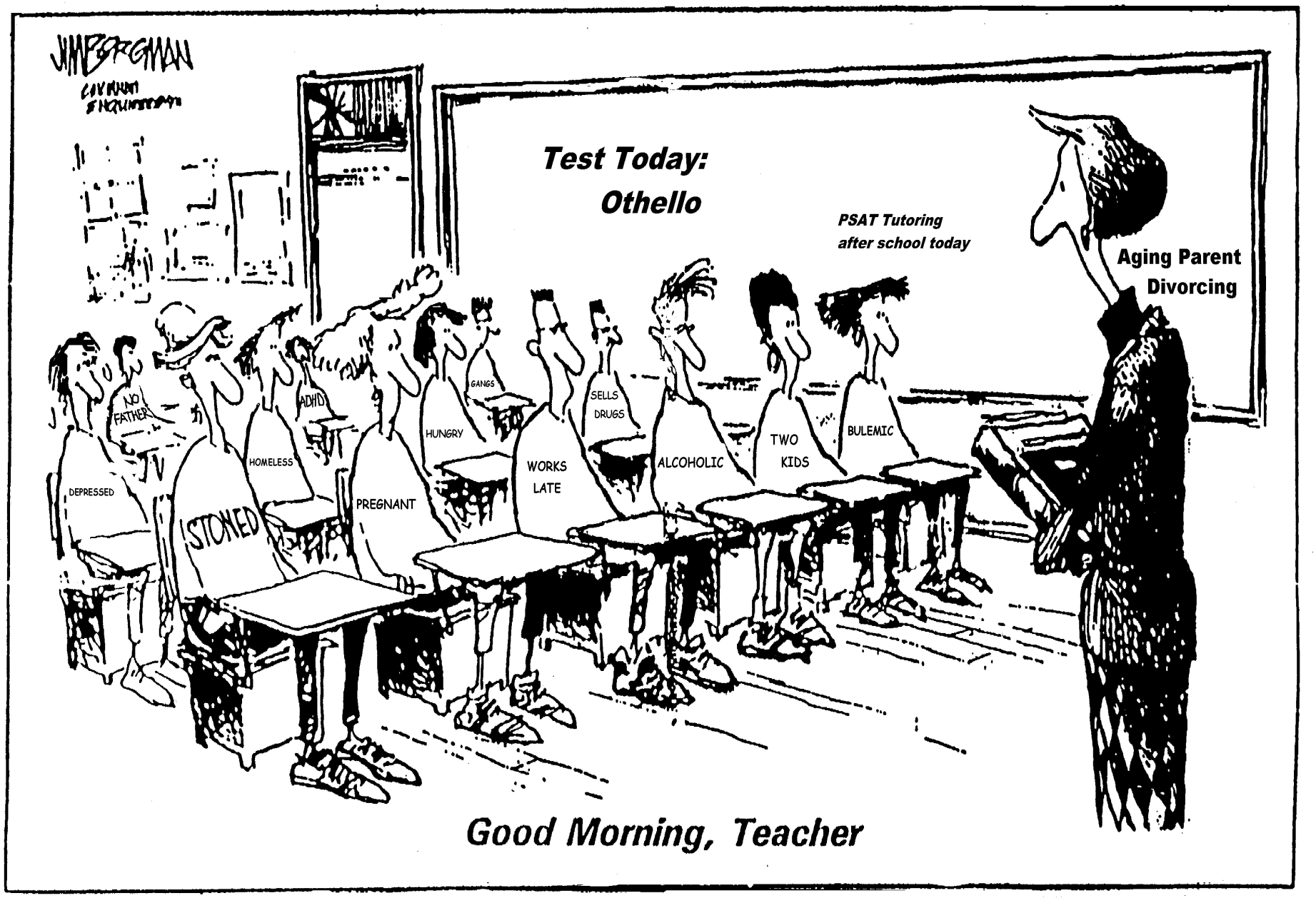
- Individual Counseling
- Group Counseling
- Family Counseling
- Psychiatrist Consultation
- Evaluation
- Classroom Presentations
- Crisis Intervention
- Connect families to resources
- School Wide- PATHS to PAX, PBIS, etc.

Why we do it

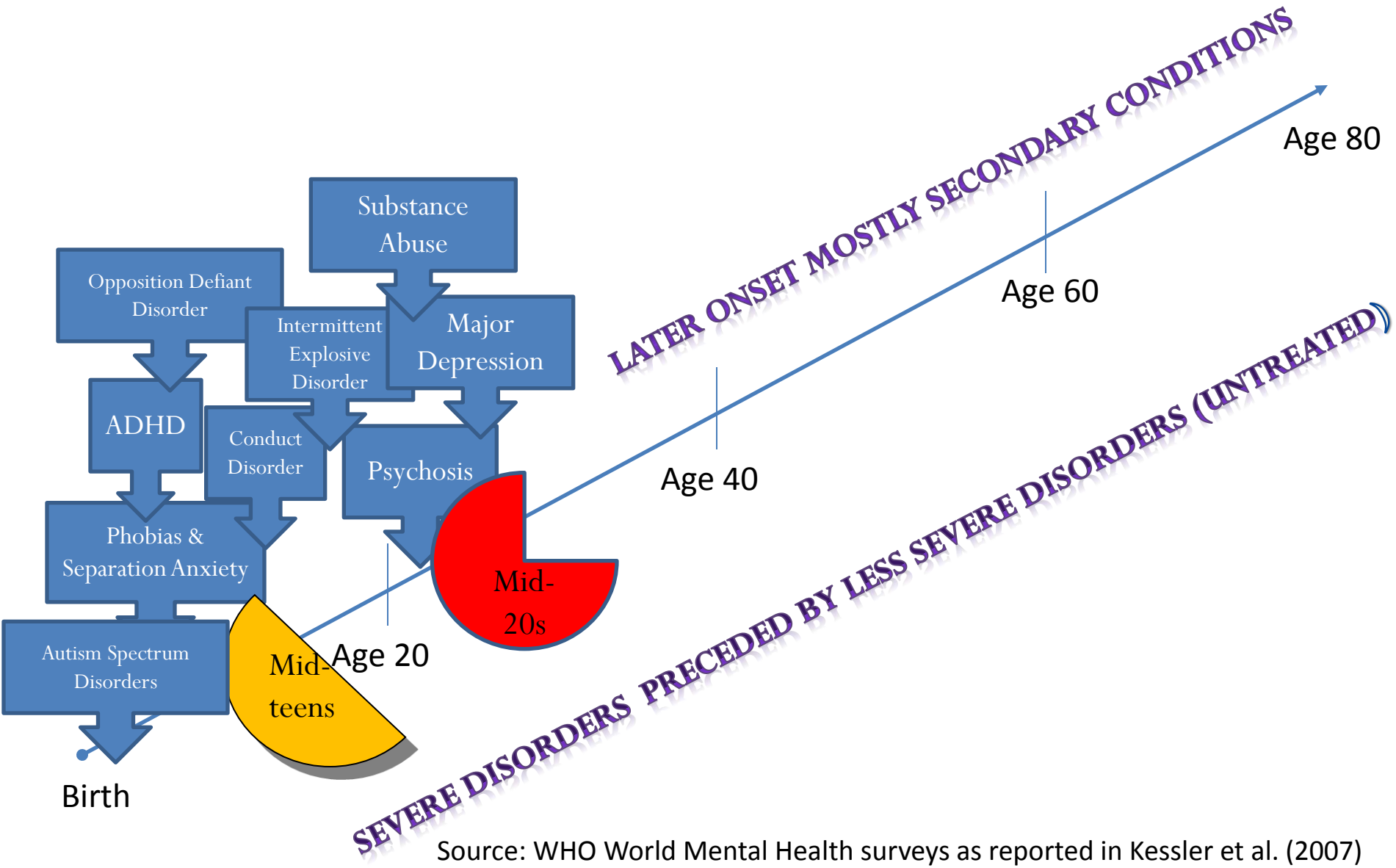
Well…

"Could someone help me with these? I'm late for math class."



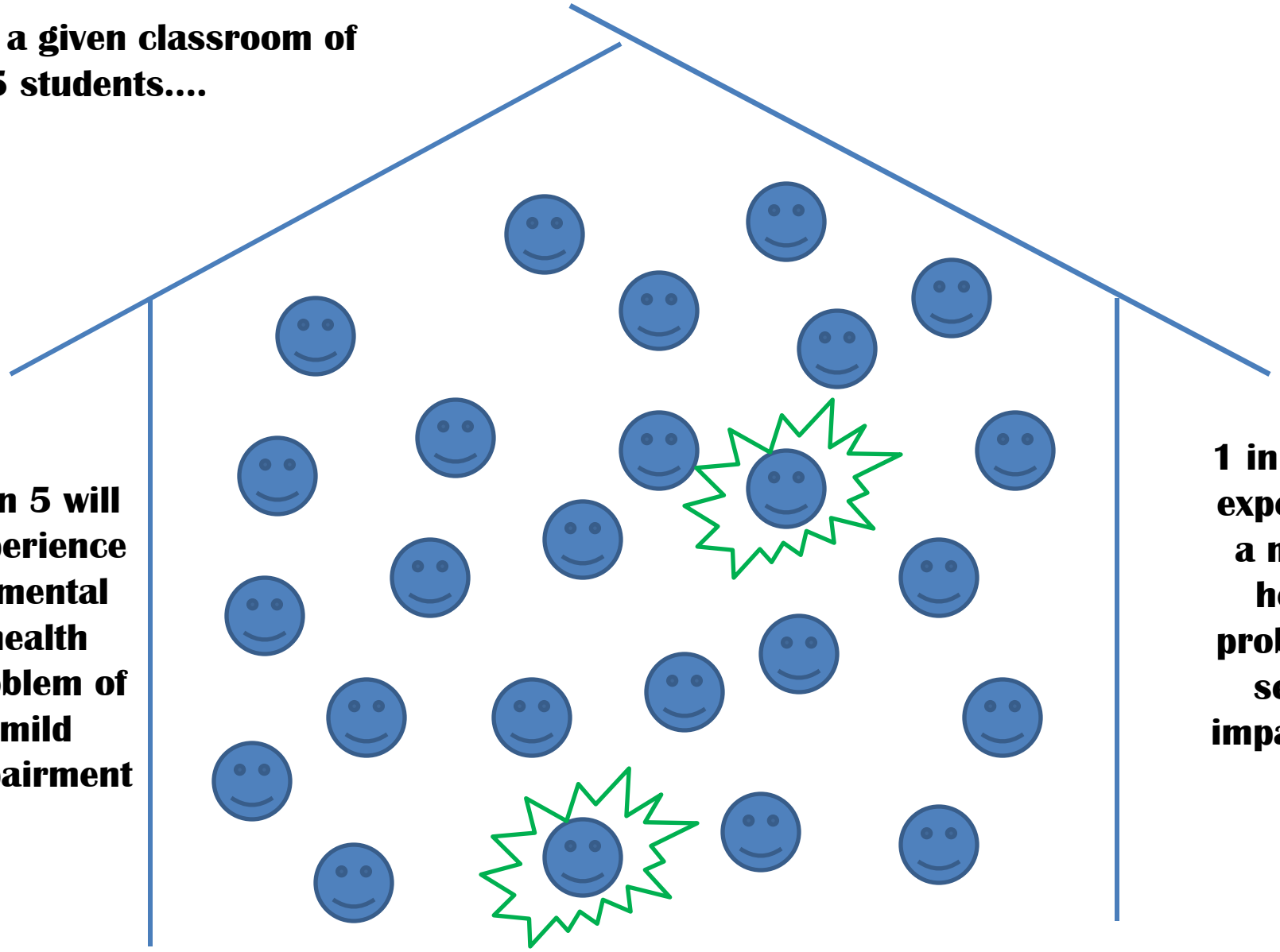

JIM BORGMAN
Test Today:
Othello
PSAT Tutoring
after school today
Aging Parent
Divorcing
DEPRESSED
NO FATHER
STONED
HOMELESS
ADHD
PREGNANT
HUNGRY
GANGS
WORKS LATE
SELLS DRUGS
ALCOHOLIC
TWO KIDS
BULEMIC
Good Morning, Teacher

Median Age of Onset: Mental Illness



Source: WHO World Mental Health surveys as reported in Kessler et al. (2007)

In a given classroom of 25 students....



1 in 5 will experience a mental health problem of mild impairment

1 in 10 will experience a mental health problem of severe impairment

Less than half of those who need it will get services

Of those who DO receive services, over 75% receive those services in schools

(Duchnowski, Kutash, & Friedman, 2002; Power, Eiraldi, Clarke, Mazzuca & Krain, 2005; Rones & Hoagwood, 2000; Wade, Mansour, & Guo, 2008)

Barriers to Treatment

- Transportation
- Trust
- Schedules
- Insurance
- Weather
- Attendance policies
- Wait lists

SMH Advantages

- Access to youth
- Clinical efficiency and productivity
- Outreach to youth with internalizing disturbances
- Enhanced capacity for prevention
- Enhanced ability to promote generalization
- Reduced stigma
- Broadened roles for clinicians
- Reduced “no-shows”
- Cost effectiveness - One study concluded that school-based services cost about a half to a quarter of what similar services would cost in the private sector (Nabors, Leff, & Metrick, 2001)

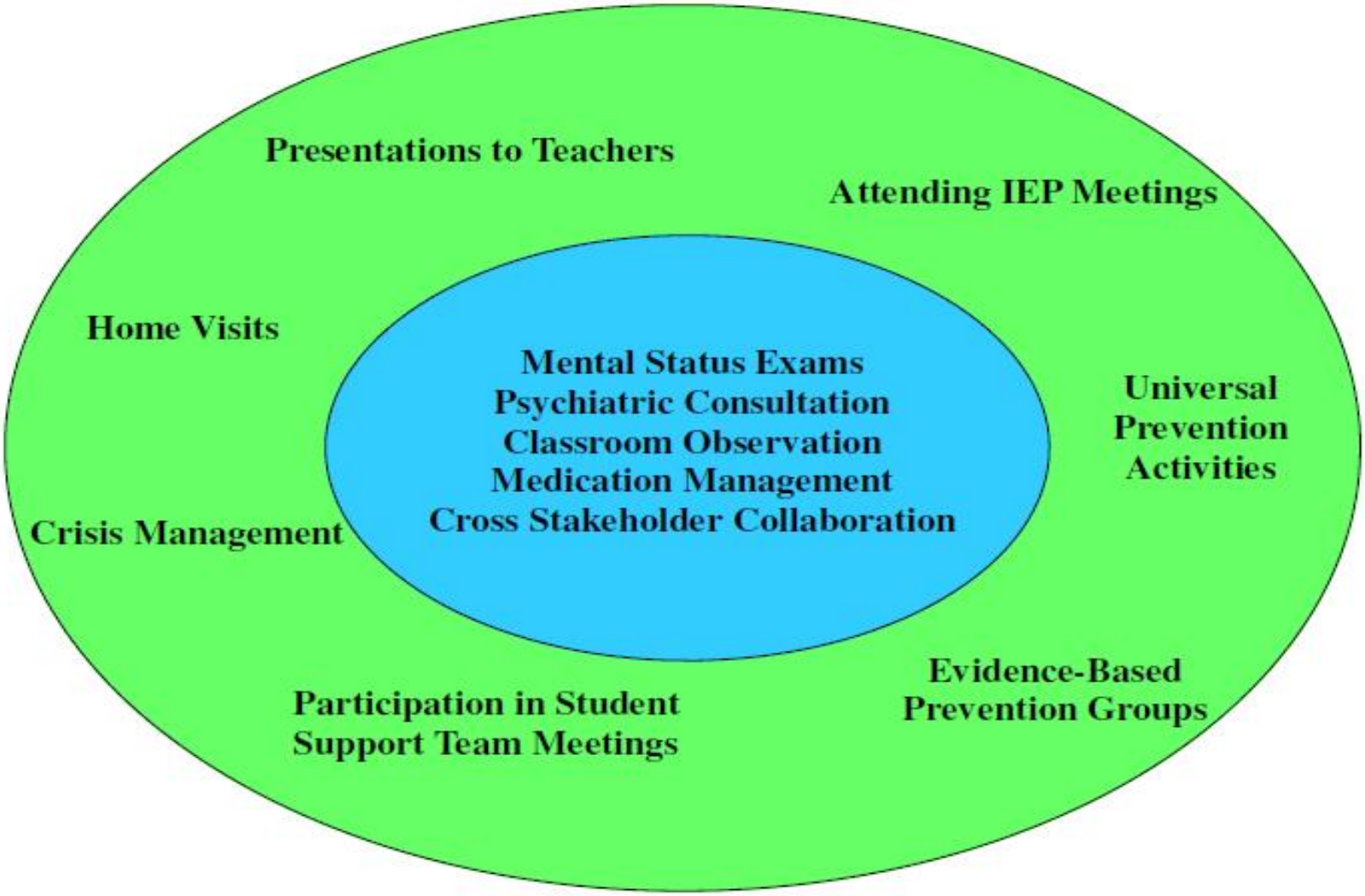
Fellows in Schools

- If therapy occurs in schools for 75% of students, due to barriers of traditional care, psychiatry can help too!
- Reducing the barriers to medication evals
- Increasing access to CHILD psychiatrists
- Child psychiatrists v. PCPs

Fellow/Clinician Roles

- The fellow will serve as a consultant to the SMHP clinicians. The SMHP clinician will take the lead in providing therapeutic interventions and overseeing the management of treatment planning for all cases

Psychiatry Roles



Fellow Responsibilities

Core Responsibilities

- Mental Status Exams/Screenings
- Psychiatric Consultation (to clinician, youth, and families)
- Observation
- Medication Management
- Completion of Paperwork
- Communication and follow through with Coordinator (Primary Placement)
- Crisis Management, particularly around medication issues

Unique Opportunities

- Teacher/faculty presentations
- Classroom presentations
- Attending school related meetings
- Home visits
- Learning about community resources
- Participating in schoolwide initiatives

Goals

- Average 2-4 students/week for individual consultation/treatment
- Meeting with Principal/Vice Principal
- Home Visit
- Presentation to School Staff or Families
- Attendance at IEP Meeting
- Attendance at Educator Meeting
- 4 Evidence-Based Prevention Activities
- 5 Classroom Observations

Psychiatry Capacity: School Mental Health

- School Mental Health Program
  - 27 schools (only 16 schools had access prior to SY 2015-2016)
  - 6-7 fellows (2 campuses each)
    - 3.5 hours per week
  - Psychiatry Faculty Supervision
  - Approximately Monthly case consultation

Telemental Health (TMH) in Schools

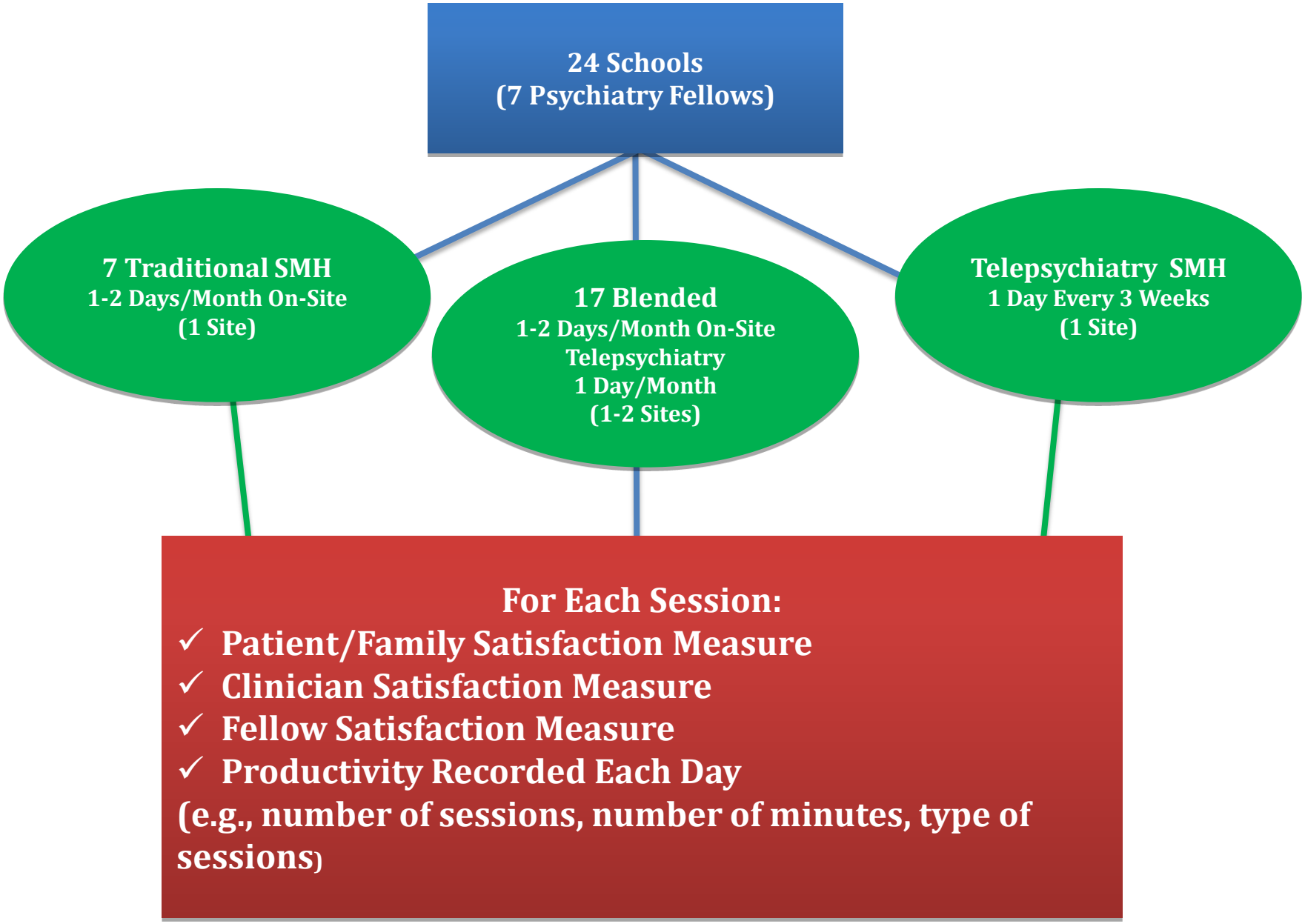
- Provides access to specialty mental health consultation and treatment
- Creates potential for greater efficiency and productivity
- Supports a multidisciplinary team approach

Maryland School Tele Mental Health

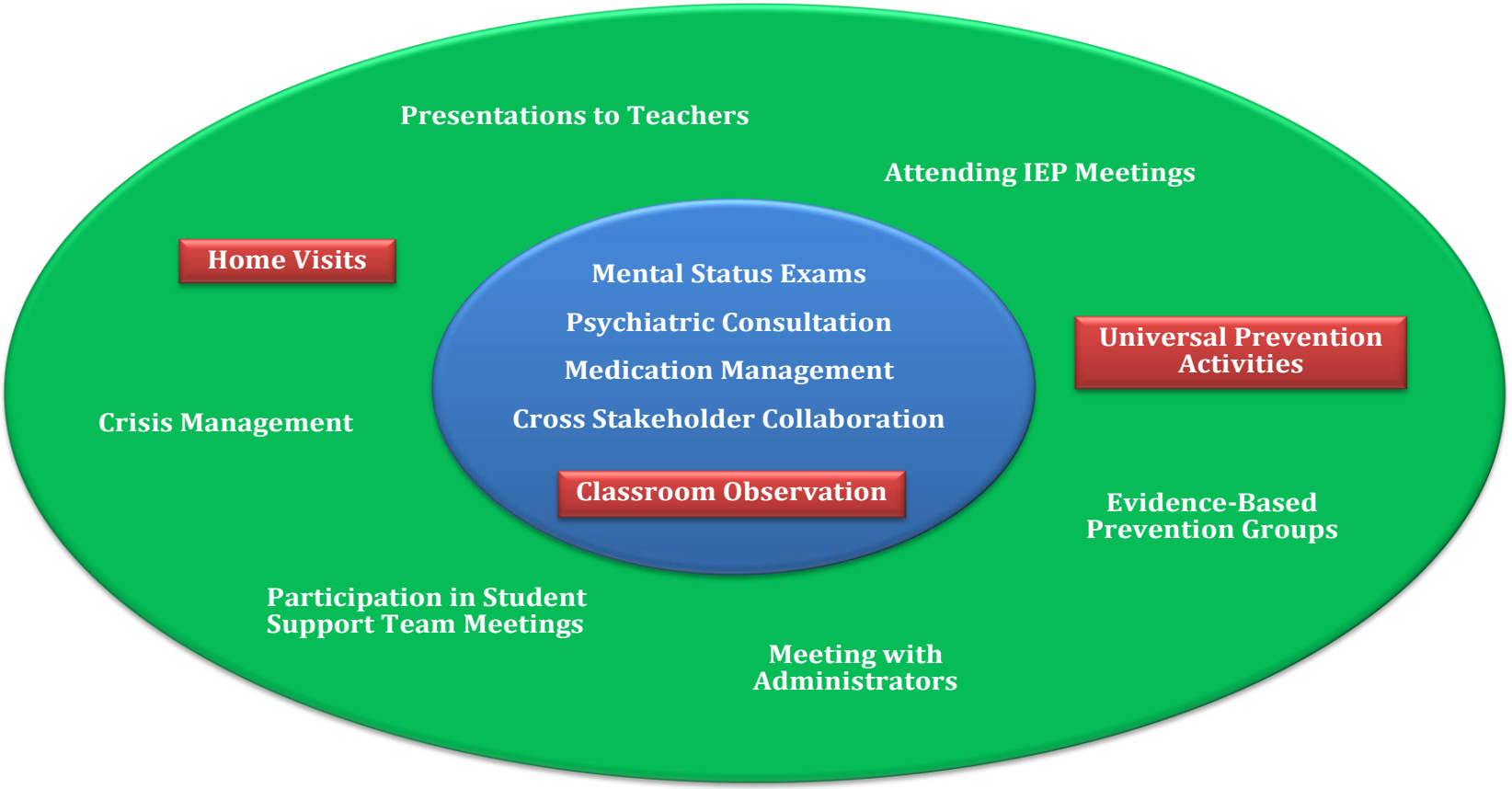
- October 2014 - Pilot
  - Expansion of telepsychiatry programs to the SMHP
  - 3 fellows providing direct care and consultation to 7 identified schools
  - Services not limited to medication management

- August 2015
  - Expansion of psychiatric services in 24 Baltimore City schools
    - Increased access to care
  - 3 armed approach
    - Telepsychiatry only, In-person only, Hybrid
  - Inclusion of all 2nd fellows in experience

CSMH
Center for School Mental Health


24 Schools
(7 Psychiatry Fellows)
7 Traditional SMH
1-2 Days/Month On-Site
(1 Site)
17 Blended
1-2 Days/Month On-Site
Telepsychiatry
1 Day/Month
(1-2 Sites)
Telepsychiatry SMH
1 Day Every 3 Weeks
(1 Site)
For Each Session:
✓ Patient/Family Satisfaction Measure
✓ Clinician Satisfaction Measure
✓ Fellow Satisfaction Measure
✓ Productivity Recorded Each Day
(e.g., number of sessions, number of minutes, type of sessions)

Psychiatry Roles



Primary Responsibilities

Additional Experiences during Rotation

Can only be Performed On-Site (Not Telepsychiatry)

Challenges to TMH in Schools

- Significant practice change for providers
  - Finding private and secure spaces in overcrowded schools
  - Providing continuity of care over breaks
  - Appt times should be respectful of “core” classes
  - Unique considerations for special needs patients
- Not all patients are suitable for telepsychiatry services
  - Knowing when to properly refer/utilize other resources
- Technology – lack of infrastructure in schools

Conclusion

- Training experience critical to psychiatry professional development
  - Experiencing the school expectations and culture
  - Greater appreciation and understanding of structures, policies, opportunities, and challenges for schools and school-based professionals.

- All of these training efforts appear to positively impact the workforce with respect to readiness and interest to provide school based care
  - 26% of the 31 CAP graduates over the past 5 years in SMH
  - 20% work in TMH

A bit more on best practices…

Treatment begins with comprehensive assessment

Why we need diagnostic labels

- Diagnosis informs treatment
  - Medication management
  - Psychosocial interventions

- Diagnosis facilitates
  - Communication between providers
  - Reimbursement for clinical services
  - Provision of educational supports
  - Research

diagnosis is not scientific fact

Consider an 8 year old boy…

Referred by teacher for "difficult behavior"

Irritable/withdrawn

Poor attention

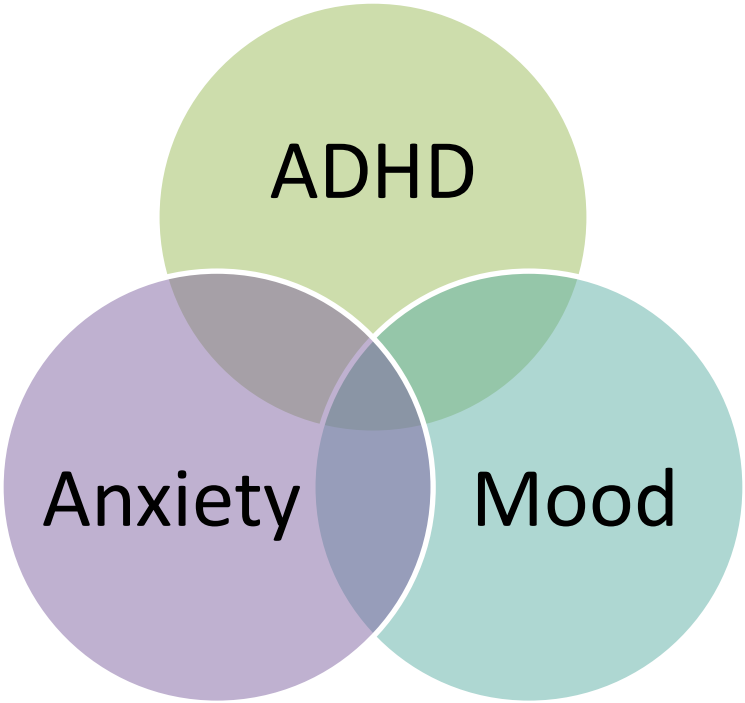
Doesn't follow through

Doesn't stay on task

Impulsive

Difficulty making friends

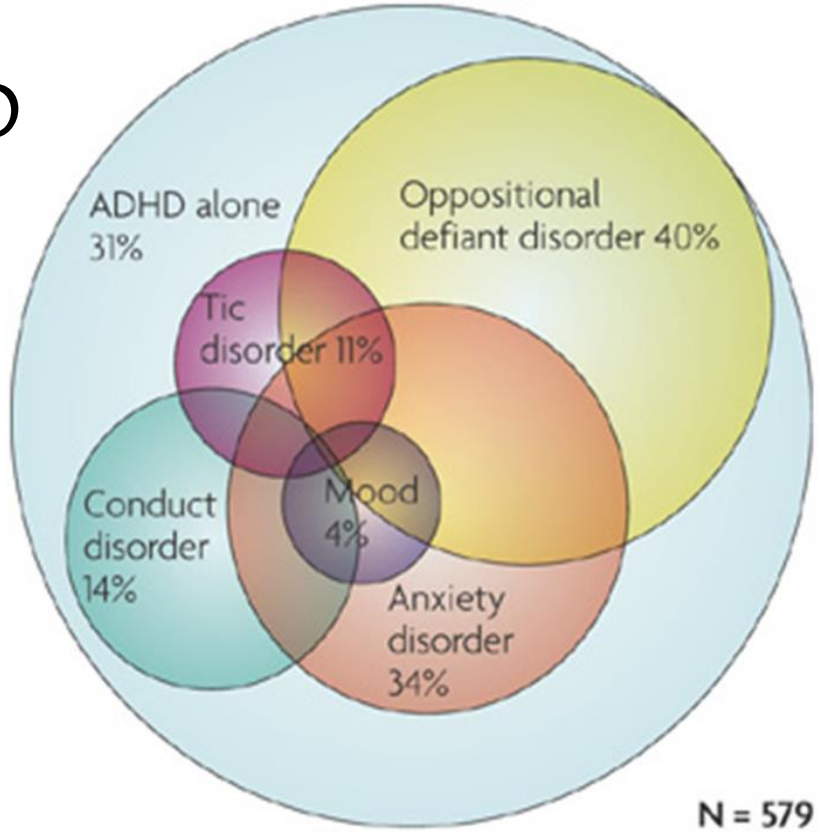
Symptoms overlap!



Getting the diagnosis right
is critical to effective treatment.

Comorbidity is the rule

- 579 youth with ADHD
- Only 31% had ADHD without other diagnosis
- ODD, Anxiety most common co-occurring diagnoses



Nature Reviews | Neuroscience

Trauma: the great masquerader

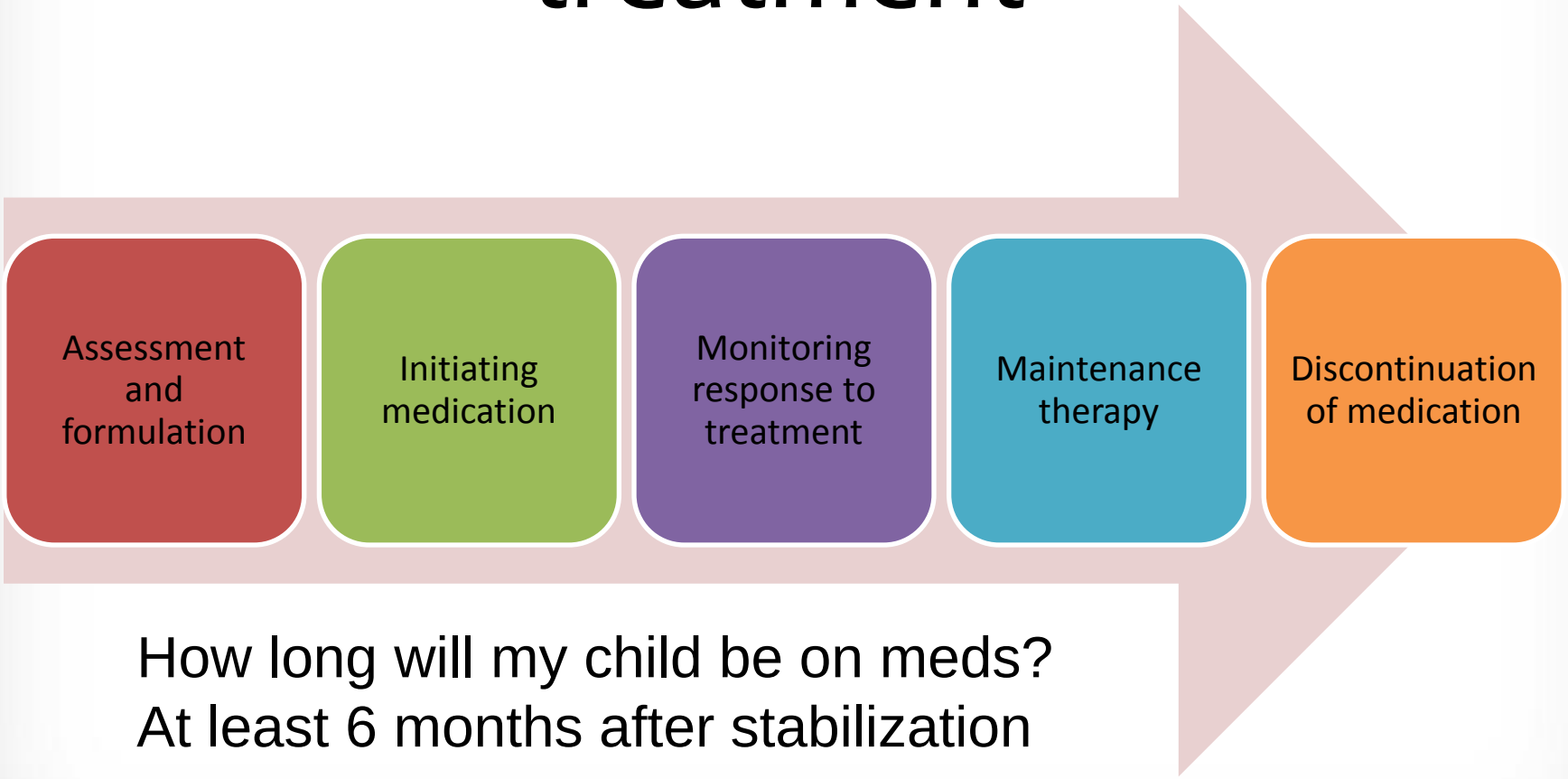
Effects may be:

- Cognitive
- Behavioral
- Emotional

Role of Medications

- Promote safety
- Relieve symptoms
- Prevent relapse
- Improve long term functioning
- Reduce long term morbidity
- Promote healthy growth, development
- ADJUNCT to good psychosocial tx

Phases of medication treatment



How long will my child be on meds?
At least 6 months after stabilization

Choice of Medication

- Evidence of efficacy
- Prominent presenting symptoms
- Side effect profile
- History of prior treatment response (or failure to respond)
- Family history of prior response
- Patient and family preference

Common Classes of Psychiatric Meds

- Stimulants
- Alpha-agonists (BP meds)
- Anxiolytics
- Antidepressants
- Mood Stabilizers
- Antipsychotics

Choice of medication

- Primary diagnosis
- Prominent presenting symptoms
- Evidence for efficacy
- Side effect profile
- History of prior treatment response
- Family history of prior response
- Patient and family preference

Informed consent and assent

- Parent consents, child assents
- Child may consent at age 16 (differs by state)
- Assess and address biases
  - against medications
  - toward medications (cure-all?)
- Discuss potential risks and benefits
  - Common minor side effects
  - Major side effects
  - Black box warnings

"Black box" warning

PROZAC®
FLUOXETINE CAPSULES, USP
FLUOXETINE ORAL SOLUTION, USP
FLUOXETINE DELAYED-RELEASE CAPSULES, USP

WARNING

Suicidality in Children and Adolescents — Antidepressants increased the risk of suicidal thinking and behavior (suicidality) in short-term studies in children and adolescents with major depressive disorder (MDD) and other psychiatric disorders. Anyone considering the use of Prozac or any other antidepressant in a child or adolescent must balance this risk with the clinical need. Patients who are started on therapy should be observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber. Prozac is approved for use in pediatric patients with MDD and obsessive compulsive disorder (OCD). (*See* WARNINGS *and* PRECAUTIONS, Pediatric Use.)

Pooled analyses of short-term (4 to 16 weeks) placebo-controlled trials of 9 antidepressant drugs (SSRIs and others) in children and adolescents with major depressive disorder (MDD), obsessive compulsive disorder (OCD), or other psychiatric disorders (a total of 24 trials involving over 4400 patients) have revealed a greater risk of adverse events representing suicidal thinking or behavior (suicidality) during the first few months of treatment in those receiving antidepressants. The average risk of such events in patients receiving antidepressants was 4%, twice the placebo risk of 2%. No suicides occurred in these trials.

Important safety considerations

- Side effects more common in children
- Risk of ⇧ suicidal thoughts/behaviors
- Treatment may unmask underlying conditions
- Medical complications including cardiac risk
- Risks of NOT-TREATING

Psychosocial factors are important to treatment response

- Teachers
- Parents
- Other school staff
- Extended family
- Other treatment providers
- Culture

Questions/Discussion

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