DCF Psychotropic Medication Advisory Committee
Monthly Meeting Notes
January 4, 2008, 1:00 PM
Riverview Hospital for Children and Youth
Middletown, CT

PRESENT:; Lesley Siegel, MD, DCF Regional Medical Director; Jacqueline Harris, MD, DCF Regional Medical Director; Joan Narad, MD, DCF Regional Medical Director; John Pitegoff, MD; CCP Pediatrician; Brian Keyes, MD, NAFI; MaryAnn D'Addario, DCF Director of Nursing; Irv Jennings, MD, FCA; Tina Spokes, RN, Hartford, DCF; Beth Muller APRN, UCHC, Charles Rich MD, Community Health Services; Blyse Soby RN DCF CQI; Carlos.A. Gonzolez M.D. IPP; Chris Malinowski APRN, Village for Families and Children; Patty Cables, APRN, Wheeler Clinic; Alton Allen, MD, DCF Psychiatrist, Riverview; Bert Plant, PhD, Director of Community Services, DCF; Ginger Bochicchio, RN, DCF, Waterbury; Anastasia Konienski, APRN; Naveen Hassam, APRN.

1. Call to order: Lesley Siegel, MD called the meeting to order at 1:15 PM in the RVH AB Conference Room.
2. Set date/time of next meeting: The next meeting is scheduled for February 1**, 2008, 1:00 PM Riverview Hospital AB Conference Room.** Future meetings are as follows: March 7; April 4; May 2; June 6; July to be announced; August 1; September 5, October 3, November 7, and December 5, 2008.
3. Announcements:
    a. Dr. Siegel was very pleased to announce that Joan Narad, MD, began the position of Regional Medical Director, Eastern Region on January 4, 2008.
    b. Dr. Siegel announced that Dr. Karen Andersson will attend the February meeting of PMAC to talk about the ASO.
    c. Dr Van Wattum is the new President of the CT Council for Child and Adolescent Psychiatry.
    d. Chris Malinowski, APRN, will be starting with the CMCU as of February 1st.
    e. The December meeting of the CCACP is re-scheduled (due to weather) to Thursday January 11th at Thali. Drs Williams, Lustbader, and Kant will be speaking.
4. Minutes: The minutes of the December, 2007 meeting were accepted with minor changes.
5. Dr. Plant began the discussion about the concern as he understood it; i.e. that the type of children being seen in community settings are more acute than in the past, which is a good thing but can be challenging for community providers especially if community providers don't have the competencies to treat these more highly disturbed children. A second concern was whether these factors might lead to an increased need for, and use of psychotropic medication. Bert's intent today is to let us know what the initiatives are to enhance the competencies of community service providers and also to hear from the group as to what we think and what else is needed.

a. Irv asked to bring up another topic, which is to better define medical responsibility especially where other non-clinical people have decision making roles which may have a major clinical impact. Lesley stated that this would be tabled for now.
b. Tina brought up the topic of kids having transitions from one service to another and what happens with prescriptions from one service to another. This topic will be tabled for future meetings.
c. Bert distributed a handout describing recent DCF training, workforce development, and program improvements.
    i. DBT trainings are being held state-wide for congregate care, group homes, etc. The training is for 3 years, designed for direct-care staff to give them DBT tools to help with children with traumatic experiences who have trouble regulating emotions.
    ii. Level 2 group homes were set up with the expectation that they provide trauma-informed care. All are required to implement a trauma informed model and train staff. Most are implementing Risking Connections. There was a recent state-wide training for group home staff on trauma-informed care as part of this initiative..
    iii. 6 state-wide Outpatient clinics are being trained on TF-CBT. This is an 18 month training model; another RFQ is going out next year to expand to more clinics. A learning collaborative model is being employed.
    iv. EMPS is being re-procured with the plan for standardized training. The bureau is looking at the model and considering expanding the scope to serve congregate care settings.
    v. The shelter system has been re-vamped. There used to be large shelters with no clinical services. They're now called "short-term assessment and respite services (STAR)". The plan is to have 14 state-wide, gender specific, STAR homes with 1:3 staffing which is enhanced on second shift, with improved training.
    vi. The CT Center for Effective Practice just kicked off a project working with outpatient clinics to study where they are in terms of evidence-based practice, service barriers, etc.
    vii. The mental health transformation grant from SAMSHA (13 million in total) which is in process just agreed to give 1.5 million over three years to improve wrap-around (i.e. what kidcare was supposed to do). CCEP will lead this.
    viii. A recent study by the ASO on foster care disruptions in CT is looking at what can be done to re-vamp foster care. **Lesley will ask Karen to talk about this next month.**
    ix. Yale received an innovation grant to implement several evidence based practices in their outpatient clinic. These

interventions include Parent Management Training and Cognitive Behavioral Therapy for Depression and Anxiety. ….

x. Logic models have been developed for residential care facilities (i.e. A logic model is essentially writing on paper what your model and approach to care is and what resources are needed). Eventually logic models will be required for all DCF-funded services.

xi. Substance abuse residential treatment is another focus, with training programs focusing on making them more family-oriented (MDFT) and also looking at residential substance abuse models in general to improve care. Peter Panzarella is leading a symposium on this topic next week.

xii. There are several workforce development initiatives in progress. Yale Department of Psychiatry is leading this under the direction of Michael Hoge. They are developing a curriculum and a course on family-based, evidence based treatment to be provided in university-based curriculum for masters level degree programs (MSW, LMFT, etc.). After the curriculum and course there will be internships to continue this learning.

xiii. There's also an initiative on web-based learning.

xiv. Marilyn Cloud has been working for 1 ½ years with extended day programs through consultation with the Consultation Center and CCEP. The initiatives center on improving their family orientation and family engagement, family-based service, and there are some start-up funds through block grant and future budget options to help them with this.

d. After describing the above, Bert asked the group for ideas for what else is needed.

e. Beth Mueller started out by thanking Bert for today's presentation. Beth stated she works around the state, and how found that while there are more services in general, she sees more problems than ever. For example, kids are failing at a higher level of care and then being sent to a lower level of care. She feels the coordination of services is getting worse rather than better. Secondly, people in charge of deciding where kids go (i.e. care coordinators) have the least amount of training, and are least able to make these decisions. As a prescriber, she feels everyone is committed to prescribing the least amount of medication; but without the right services this can't happen. She also said APRNs and psychiatrists are asked to manage medications of patients they're no longer following (Irv's point). Beth said that a basic standard should be that physicians are responsible to follow someone until someone is providing follow-up. Bert said that his office manages the contracts with the providers. Bert said he will send a list of who oversees which part of the continuum to this group so we know where to direct specific concerns, and stressed that he needs more specific

feedback. In the original proposal they asked for a lead agency in each area to maintain accountability…..this was voted out by the legislature. More specific feedback will help.

f. Alton pointed out that a key issue is the gate in and out of each program. Alton suggested following the kids that move a lot to see what's really happening. **Lesley will ask Karen to talk about this next month as well.** Irv said that foster care is a hole in what they can study, since they don't authorize this. Alton also asked for more a specific study of where the service gaps are. Bert said that reality is that we have 1/10th of the money/services we need.
g. Alton brought up the ER overstay issue. **Lesley will ask Karen to talk about this next month; Bert offered to join her.**
h. John Pitegoff brought up the problem of over 18 year olds. Bert agreed there needs to be more services developed for this age group. Alton said that High Meadows already has a unit with 7 kids over age 18. Lesley said the recent tragedy in Hartford has made more state officials interested in this age range. Bert said his primary focus has been on doing a much better job on higher quality services earlier, with better coordination and integration, which should have a major impact on the emotional health of this older adolescent population. **Bert suggested that Sara Lourie be invited to a future meeting to discuss the topic of transitioning youth.**
i. Beth said many of the new programs haven't come with prescribers- she asked Bert to look at that; she thinks one of the biggest offenders are some of the IICAPS program.
j. Beth also brought up the importance of establishing more Job Programs (age 12 up); internships; apprenticeships, etc.
k. Irv said that IICAPS is a model that is fee for service, growing rapidly, and needs to be paid a lot of attention to. Waterbury now has 13 teams; Torrington now has 6 teams, etc. They're growing according to the market demand; but there seems to be a virtually unlimited need. Bert said he would like to hear about teams that don't have enough psychiatry time.
l. Pieter Jost asked if there was any IICAPS outcome data. Bert said that results he has seen are very promising, and Irv said this program essentially doesn't cost the state money. Alton said that one problem is third party reimbursement for child psychiatrists and IICAPS (which Irv disagreed with).

6. Lesley distributed a copy of the December JJACAP article "Psychopharmacological Treatment for Very Young Children: Contexts and Guidelines". She also distributed a copy of a summary of the article, for everyone's future reference and also to help guide today's discussion. Pieter Jost asked if there was a definition of "very young children", and Lesley stated that it appeared they were using "pre-kindergarten" as a general descriptor (as opposed to an exact age). Alton stated he didn't agree that DSM IV diagnoses were specific enough for use in preschoolers (as opposed to the authors'

conclusion that many DSM-IV diagnoses, such as MDE, PTSD, Disruptive Behavior Disorders, ADHD, and autism are empirically valid in preschoolers). He also pointed out that most young children are diagnosed with many co-morbid conditions. Lesley stated that she hoped that the group developing the DSM-V would seriously consider Developmental Trauma Disorder. Brian stated that the DSM-V work group is just starting, and the projected completion date is 2012. Pieter Jost said he didn't feel the medication guidelines were that helpful since there have been so few good studies in this age group. In the discussion regarding the use of Melatonin for sleep disorders, the conclusion of the group was not to change past recommendations- i.e. that Melatonin shouldn't be on PMAC's list of approved medications but that the CMCU should feel free to approve its use depending on the circumstance. Beth also pointed out that as of June '08 dietary supplements will be monitored by the FDA so this committee should probably re-consider the use of all supplements.

7. The agenda topic of planning for a statewide psychopharmacology conference was reviewed. The group felt that before developing a subcommittee they would like to have further discussion (**at next month's meeting**) of the goals for the conference. They also felt it would be important to try to get CME credit for the conference.
8. A final topic was the subject of psychotropic medication approval still coming through the managed care organizations as opposed to being centralized through the ASO. The group thought that Governor Rell changed this rule last month. Lesley said she would ask Aurele (who previously sat on this statewide subcommittee) to address this at the February meeting.

Respectfully submitted,

Lesley Siegel, MD
Regional Medical Director, Southern Region, DCF