Nebraska Children's Commission

Fifteenth Meeting
September 17, 2013
9:00 AM – 12:00 PM
Country Inn and Suites, Lighthouse Room
5353 N. 27th Street, Lincoln, NE

Call to Order

Karen Authier called the meeting to order at 9:05am and noted that the Open Meetings Act information was posted in the room as required by state law.

Introduction of New Member

Legislative Bill 269 (LB269), signed by the Governor on June 4, 2013, added new members to the Commission. Andrea Miller was appointed by the Governor as a representative of a federally recognized Indian tribe residing within the State of Nebraska. Andrea is an attorney in western Nebraska and is a member of the Oglala Lakota Tribe. She is a voting member of the Children's Commission.

Roll Call

Commission Members present: Pam Allen, Karen Authier, Nancy Forney, Candy Kennedy-Goergen, Kim Hawekotte, Gene Klein, Martin Klein, Andrea Miller, David Newell, Mary Jo Pankoke, Dale Shotkoski, and Susan Staab.

Commission Members absent: Beth Baxter, Janteice Holston, Norman Langemach, Jennifer Nelson, John Northrop, and Becky Sorensen.

Ex Officio Members present: Ellen Brokofsky, Senator Colby Coash, Hon. Linda Porter, Thomas Pristow, Julie Rogers, Vicky Weisz, and Kerry Winterer.

Ex Officio Members absent: Senator Kathy Campbell and Senator Jeremy Nordquist.

Also in attendance: Leesa Sorensen from the Nebraska Children's Commission.

Approval of Agenda

A motion was made by Mary Jo Pankoke to approve the agenda, as written. The motion was seconded by Marty Klein. Voting yes: Pam Allen, Karen Authier, Nancy Forney, Candy Kennedy-Goergen, Kim Hawekotte, Gene Klein, Martin Klein, Andrea Miller, David Newell, Mary Jo Pankoke, Dale Shotkoski, and Susan Staab. Voting no: none. Beth Baxter, Janteice

Holston, Norman Langemach, Jennifer Nelson, John Northrop, and Becky Sorensen were absent. Motion carried.

Approval of August 20, 2013, Minutes

A motion was made by Candy Kennedy-Goergen to approve minutes of the August 20, 2013, meeting. The motion was seconded by Pam Allen. Voting yes: Pam Allen, Karen Authier, Nancy Forney, Candy Kennedy-Goergen, Kim Hawekotte, Gene Klein, Martin Klein, Andrea Miller, David Newell, Mary Jo Pankoke, Dale Shotkoski, and Susan Staab. Voting no: none. Beth Baxter, Janteice Holston, Norman Langemach, Jennifer Nelson, John Northrop, and Becky Sorensen were absent. Motion carried.

Chairperson's Report

Karen Authier provided a brief chair's report. The Nebraska Children's Commission received 90 applications for the Policy Analyst position. Thirty of those applications were deemed eligible to move forward in the process. The Commission website is still under construction and Leesa is working on contact lists for the committees and workgroups. Karen then provided an overview of the items on the agenda including and advised members that the meetings for October and November would be extended to 3:30pm to allow the Commission members time to address the various tasks required by statute.

Public Comment

Teresa Dameron from the Santee Sioux Nation Indian Center provided Commission members with information on the system of care planning that is being done to create a more culturally sensitive system of care model. Because of the group's work they have created a Society of Care model and have created a design for a Natural Helpers network. Teresa provided Commission members with a document that contained the key elements of the Society of Care model that has been created. Additional information is available at www.societyofcare.org.

Foster Care Reimbursement Rate Committee Report

Karen Authier introduced Peg Harriott who will be chairing the Foster Care Reimbursement Rate Committee. Peg gave a verbal report on the work that has been done to set up the first meeting. The committee's first meeting is scheduled for Friday, October 18 from 9:00am to noon. The committee will be reviewing the work of the previous committee, monitoring the Assessment Pilot Project and developing recommendations regarding foster care rates, including attention to administrative rate issue for agency based foster care in accordance with the responsibilities assigned by LB530.

Level of Care Assessment Pilot Project Report

Thomas Pristow provided a one page written report on the LB530 Level of Care Assessments pilot. The report included milestones for work done from June through September of 2013. During the pilot project a minimum of 350 assessments will be completed between the urban and rural pilot sites.

A motion was made by Susan Staab to approve the Level of Care Assessment report and submit the report on behalf of the Nebraska Children's Commission as the progress report required by LB 530. The motion was seconded by Mary Jo Pankoke. Voting yes: Pam Allen, Karen Authier, Nancy Forney, Candy Kennedy-Goergen, Kim Hawekotte, Gene Klein, Martin Klein, Andrea Miller, David Newell, Mary Jo Pankoke, Dale Shotkoski, and Susan Staab. Voting no: none. Beth Baxter, Janteice Holston, Norman Langemach, Jennifer Nelson, John Northrop, and Becky Sorensen were absent. Motion carried.

Juvenile Services (OJS) Committee Report

Ellen Brokofsky and Martin Klein provided an update on the Juvenile Services Committee, including a written report.

The Juvenile Services (OJS) committee received 3 proposals for the Technical Consultant/Facilitator/Writer position. On September 5, 2013, Schmeeckle Research Inc. was selected as the contractor for this project.

The Juvenile Services (OJS) Committee met on September 10, 2013. Joan Frances facilitated the discussion with assistance from Joyce Schmeeckle and Will Schmeeckle. The committee created draft framework recommendations to add to the strategic planning efforts. The committee will meet again for facilitated discussion on October 8, 2013. The contractor will be working with the Juvenile Services (OJS) Committee to facilitate the remaining strategic planning efforts and write a report that will fulfill the requirements as outlined in LB 561. It is the intention of the committee that the finalized draft Juvenile Services (OJS) committee report will be delivered to the Nebraska Children's Commission for consideration at its November 19, 2013 meeting.

A motion was made by Mary Klein to approve Schmeeckle Research Inc. as the contractor for providing the facilitation and to write the report as required by LB 561. The motion was seconded by Susan Staab. Voting yes: Pam Allen, Karen Authier, Nancy Forney, Candy Kennedy-Goergen, Kim Hawekotte, Gene Klein, Martin Klein, Andrea Miller, David Newell, Mary Jo Pankoke, Dale Shotkoski, and Susan Staab. Voting no: none. Beth Baxter, Janteice Holston, Norman Langemach, Jennifer Nelson, John Northrop, and Becky Sorensen were absent. Motion carried.

Alternative Response Progress Report

Jim Blue, Gene Klein, Emily Kluver, and Thomas Pristow provided a panel presentation on the alternative response implementation planning that is underway in accordance with provisions of LB 561. Emily and Thomas provided an overview of the Department of Health and Human Services (DHHS) planning meetings that have been taking place. Jim and Gene then provided information on issues the Commission may want to consider as the alternative response plan is developed. Jim and Gene reviewed critical questions and issues that still need to be answered and addressed for families that are diverted into the alternative response path: 1) Who will oversee participation?; 2) What services will be available?; 3) Who will provide those services? DHHS or private entities?; 4) Who will fund the payment for services? IV-E or some other source?; 5) What structure will be used for youth who are not under court jurisdiction ? Gene also reviewed the need for a process for stakeholders to weigh in on the issues outside of the DHHS meeting process.

Senator Coash then provided some information on the background of the process that led to alternative response being added to the LB 561 legislation and the 19 points that he was hoping the Nebraska Children's Commission would review related to the DHHS alternative response report. Senator Coash offered to provide additional information to the Commission members on these specific points.

Gene Klein then made a motion to create a committee of the Nebraska Children's Commission to specifically focus on the 19 points of the legislation and to review and comment on the Alternative Response report from DHHS. The motion was seconded by Mary Jo Pankoke. The Commission members discussed the motion and the process of creating another committee of the Commission. Based on concerns, David Newell then suggested a friendly amendment to the motion that would create the group as a sub-workgroup of the System of Care workgroup to allow more flexibility in completing the work in such a short time frame. Based on the discussion Karen Authier suggested that a group be convened as a taskforce for the purpose of dealing with this single issue. The Commission members expressed support for the more informal taskforce process to make recommendations back to the full Commission. Based on Karen's suggestion, Gene Klein withdrew his motion. Karen indicated that she would provide additional information on the taskforce at a future meeting.

Young Adult Voluntary Services and Support Advisory Committee Report

Mary Jo Pankoke gave opening comments about the work of the Young Adult Voluntary Services and Support Advisory (YAVSSA) Committee and provided a report with the group's initial recommendations. Mary Jo Pankoke, Nathan Busch, Sara Goscha, Mary Kate Gulick, Sarah Helvey, Judge Douglas F. Johnson, Mary Fraser Meints, Ronda Newman, Jenny Skala, Amy West and Amy Williams provided a panel presentation on the recommendations from each of the six workgroups: 1) Eligibility and Transition from Current Service Array; 2) Case Management and Supportive Services; 3) Placement; 4) Case Oversight; 5) Communication/Marketing; and 6) State Extended Guardianship Assistance Program.

Mary Jo indicated that the YAVSSA Committee will be continuing to meet to future develop the recommendations for the report that is due on December 15, 2013.

Mary Jo Pankoke then made a motion to accept the report of the Young Adult Voluntary Services and Support Advisory committee as written and have the report forwarded on to the Legislature and Governor as required by LB216. The motion was seconded by Susan Staab. Voting yes: Pam Allen, Karen Authier, Nancy Forney, Candy Kennedy-Goergen, Gene Klein, Martin Klein, Andrea Miller, David Newell, Mary Jo Pankoke, Dale Shotkoski, and Susan Staab. Voting no: Kim Hawekotte. Beth Baxter, Janteice Holston, Norman Langemach, Jennifer Nelson, John Northrop, and Becky Sorensen were absent. Motion carried.

New Business

Next Meeting Date

The next meeting is October 16, 2013, 9:00am-3:00pm at the Country Inn and Suites, 5353 North 27th Street, Lincoln, Nebraska. The meeting will be held in the Lighthouse room.

Adjourn

A motion was made by Mary Jo Pankoke to adjourn the meeting, seconded by Kim Hawekotte. The meeting adjourned at 11:58am.

NEBRASKA ALLIANCE
OF
CHILD ADVOCACY CENTERS

NATIONAL
CHILDREN'S
ALLIANCE®

October 8, 2013

Leesa Sorensen
Nebraska Children's Commission
521 S. 14th, Suite 401
Lincoln NE 68508

Dear Ms. Sorensen:

I've enclosed enough copies of the enclosed final report, "Child Welfare Non-Court Involved Cases: A Report to the Health and Human Services Committee" for you to distribute to the Children's Commission. The report details the combined findings of the seven Child Advocacy Centers service areas' review of the non-court involved cases by the multi-disciplinary teams from the time period of September 1, 2102 through July 31, 2013.

Please feel free to contact me if you or the Commission has any questions regarding this enclosed report. Gene Klein is also available if you have any questions, 402-595-1326. Thank you so much for disseminating these!

Sincerely-

Ivy Svoboda

Ivy Svoboda, MSW
State Chapter Coordinator
NE Alliance of Child Advocacy Centers

NEBRASKA ALLIANCE OF CHILD ADVOCACY CENTERS

CHILD WELFARE NON-COURT INVOLVED CASES: A REPORT TO THE HEALTH AND HUMAN SERVICES COMMITTEE

SEPTEMBER 2013

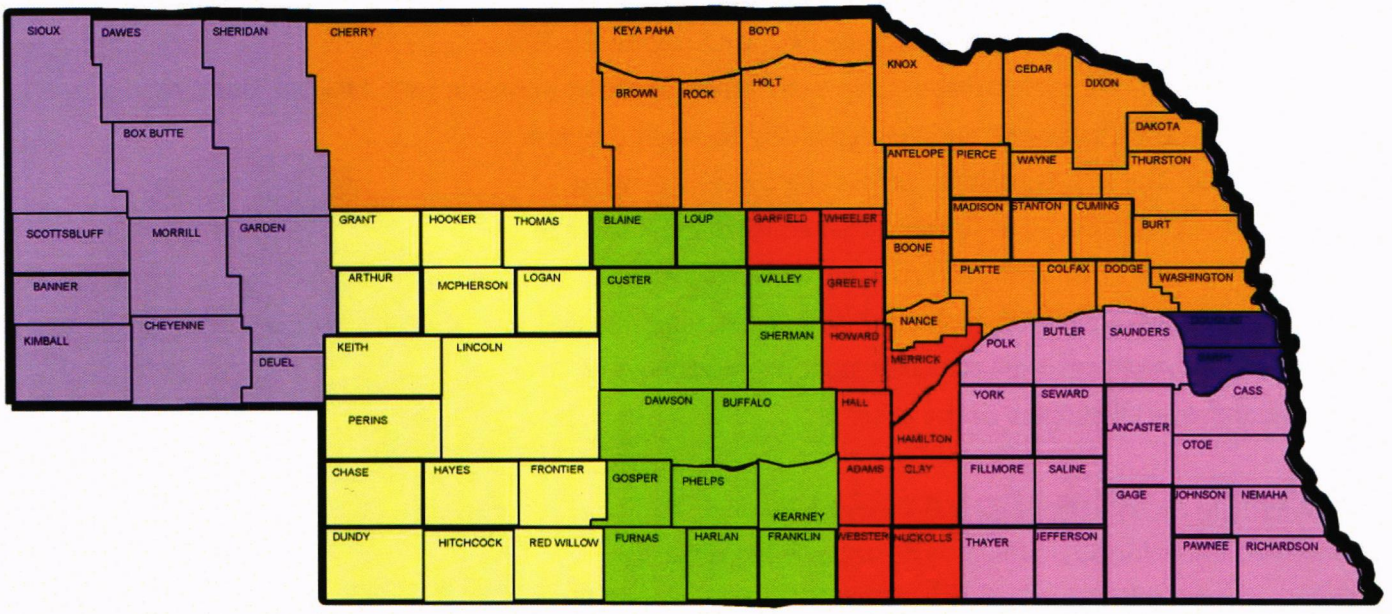
The Nebraska Alliance

The Nebraska Alliance of Child Advocacy Centers consists of seven (7) fully accredited Child Advocacy Centers (CACs) with the mission to enhance Nebraska's response to child abuse. Our State Chapter was awarded State Chapter Accreditation by National Children's Alliance (NCA) following an extensive application and site review process. Accreditation is the highest level of membership with NCA and denotes excellence in service provision. As an accredited State Chapter, the Nebraska Alliance has been recognized for providing CACs and multi-disciplinary teams with the resources they need to consistently offer unique and vital services to child victims of abuse and their families; and for serving as the voice for all CACs in Nebraska.

Capstone Scottsbluff/Gering
Contact: Debi Fitts
director@capstonenebraska.com
308-632-7274

Northeast NE CAC Norfolk
Contact: Mark Zimmerer
mazimmerer@frhs.org
402-644-7402

Project Harmony Omaha
Contact: Gene Klein
gklein@projectharmony.com
402-595-1326



Bridge of Hope North Platte
Contact: Anne Power
anne@bridge-of-hope-cac.org
308-534-4064

Central Nebraska CAC Grand Island
Contact: Brady Kerkman
director@cn-cac.org
308-385-5238

Child Advocacy Center Lincoln
Contact: Lynn Ayers
lynn@smvoices.org
402-476-3200

Family Advocacy Network Kearney
Contact: Jamie Vetter
jdirwin@familyadvocacynetwork.org
308-865-7492

LB1160 Overview

LB1160 Reads:

"Each service area administrator and any lead agency or the pilot project shall provide monthly reports to the child advocacy center that corresponds with the geographic location of the child regarding the services provided through the department or a lead agency or the pilot project when the child is identified as a voluntary or non-court-involved child welfare case. The monthly report shall include the plan implemented by the department, lead agency, or the pilot project for the child and family and the status of compliance by the family with the plan. The child advocacy center shall report to the Health and Human Services Committee of the Legislature on September 15, 2012, and every September 15 thereafter, or more frequently if requested by the committee."

Child Advocacy Center Role in LB1160

Child Advocacy Centers (CACs) have worked with the Department of Health and Human Services to obtain data on cases that are non-court involved. The CACs run reports from NFOCUS on a monthly basis and the Coordinators at each CAC take it to Multi-Disciplinary Team meetings for review following guidelines set forth by Nebraska Revised Statutes 28-728 to 28-729 .

Over the past year through collaboration with other CACs in the Nebraska Alliance, the CAC Coordinators have developed and refined a way to track the case information so they are consistent across the state as to what information is collected, shared, and obtained from the Teams at the time of review. The areas of focus are: case discussion/ review, current case plan establishment, and at the time of case closing— the overall parental compliance, appropriateness of services, and overall success of the case.

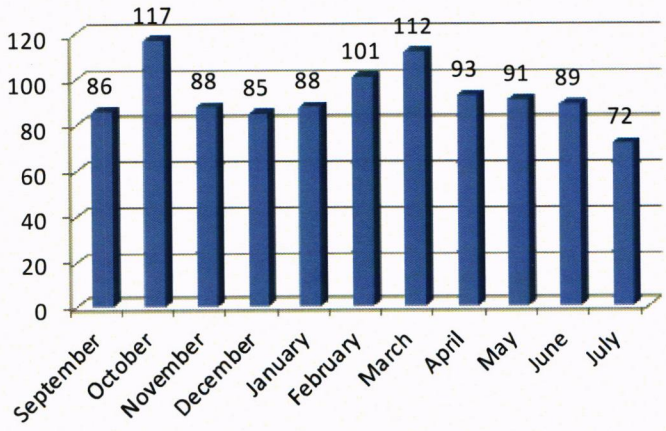
What is a Non-Court Case?

Non-court cases include families who are offered ongoing services provided by DHHS (or a contracted agency like NFC), but do not have juvenile court involvement. These services are voluntary, and may include family support, case management, and referrals to community agencies for mental health, substance abuse, or other resource assistance. The vast majority of children involved in these cases remain in their homes. Others may stay with relatives or family friends until the safety threat which brought the family to DHHS attention is resolved.

New Non-Court Cases

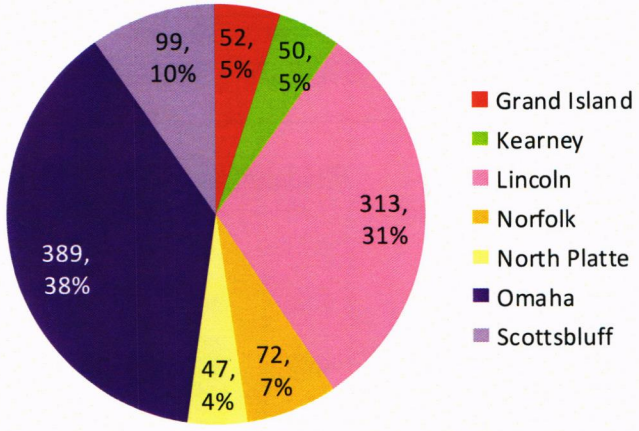
From September 1, 2012 to July 31, 2013, 1,022 new non-court cases opened throughout the state. Figure 1 is a representation of the number of cases that opened statewide each month during the reporting period. An average of 93 cases opened per month. Figure 2 shows the number of non-court cases that opened in each Child Advocacy Center (CAC) region during the reporting period. Almost 70% of new non-court cases opened in the areas served by Project Harmony and the Lincoln Child Advocacy Center.

FIGURE 1. Number of New Non-Court Cases



TOTAL: 1022 New Non-Court Cases

FIGURE 2. Percentage of the Total Number of New Cases Distributed to Each CAC



Estimated 2500 children served

FIGURE 3. Percent of New Cases with a Case Plan

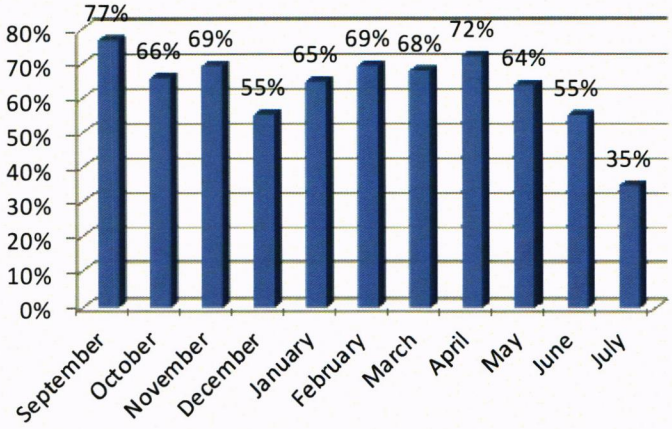


Figure 3 shows the percentage of non-court cases that had an active case plan. A case plan identifies the goals and services the families must achieve with the assistance of the case manager. On average, 64% of these cases had an active case plan.

Case Closings

During the reporting period, 678 non-court cases closed without court intervention. On average, cases stayed open 144 days (almost 5 months).

At closing, non-court cases are reviewed at team meetings coordinated by each CAC. These teams are comprised of county attorneys, initial assessment workers, ongoing caseworkers, coordinators from the CAC and professionals from the community who have expertise in child and family issues. Each non-court case is evaluated on the following criteria: overall success of case, overall parental compliance, and overall appropriateness of services offered to the family. Table 1 provides definitions for each criterion.

TABLE 1. Definitions of Criteria Examined at Case Closure

Measure	Possible Outcomes
Overall Success of the Case	**Completely:** Family met all case plan goals
	Somewhat: Family met some case plan goals
	Not at all: Family did not meet any case plan goals or refused voluntary services.
Parental Compliance	**Good:** Parents are consistently working toward completion of case plan.
	Fair: Parents are inconsistently working toward completion of case plan (e.g. they need multiple reminders to complete tasks, make appointments, etc).
	Poor: Parents are not working towards completion of case plan and/or they refused voluntary services.
Appropriateness of Services Offered to the Family	**All appropriate:** Caseworker referred family to all services that could help them.
	Some appropriate: Caseworker referred family to some services, but may have missed others (e.g. referred for substance abuse services, but not DV services in a family with clear DV issues)
	None appropriate: Caseworker did not refer family to any services that could help them.
	No services offered: Caseworker did not have a chance to refer to services (e.g. family refused voluntary services).

Figure 4 shows that statewide, 83% of closed cases were either "completely successful" or "somewhat successful." Figure 5 shows that 49% of non-court involved caretakers had "good parental compliance." Finally, Figure 6 shows that 62% of cases closed with an agreement that all of the services provided to the family were appropriate.

FIGURE 4. Overall Success Rate of Closed Non-Court Cases

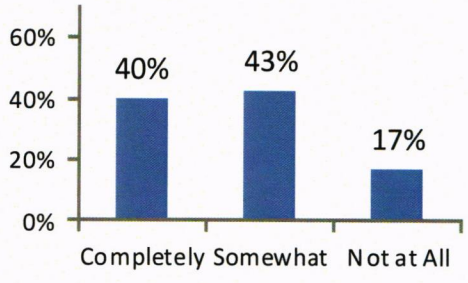


FIGURE 5. Overall Parental Compliance

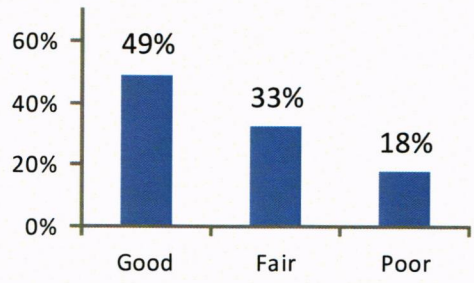
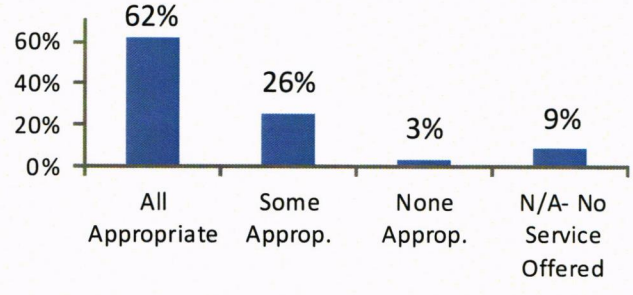


FIGURE 6. Overall Appropriateness of Services



Court Filings

At times, it may be necessary to file an affidavit in court on a non-court involved family who needs more intensive supervision. During the reporting period, there were 185 court filings (18% of the 1,022 new non-court cases). On average, 113 days (almost 4 months) passed between case opening and court filing. Figure 7 is a breakdown of the number of court filings by CAC.

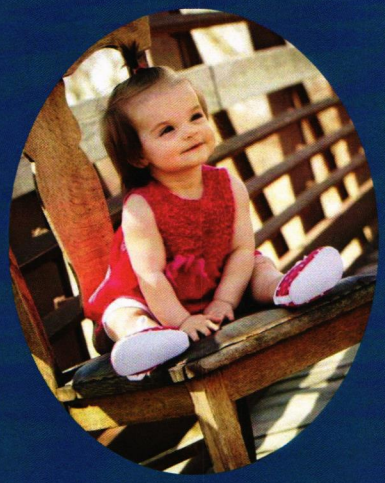
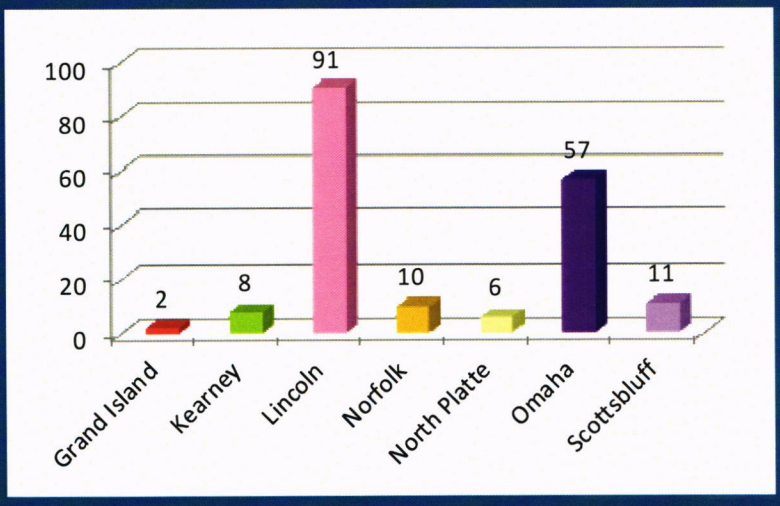


FIGURE 7. Court Filings by CAC



Implications

Each CAC submitted an annual 1160 narrative which outlined successes, areas for improvement and systems' issues. The following is an analysis of common themes that emerged from each CAC's 1160 narrative.

AREAS FOR IMPROVEMENT

1. Data Collection and Documentation

Several CACs commented that the percentage of non-court involved cases with an active case plan did not equal 100%. One CAC wrote that most families probably have case plans, but they are not being documented in N-FOCUS. Without a case plan, it can be difficult for the multi-disciplinary teams to thoroughly evaluate each family's goals and potential service needs.

Another documentation issue revolved around safety plans, which are required for non-court involved children who are deemed "conditionally safe" during the initial assessment. Safety plans should include the specific safety threats that were identified, along with specific objectives that will be used in order to mitigate these threats. All of this information should be documented in N-FOCUS in a timely manner.

A "data delay" was noted in a few CAC 1160 narratives. Some CACs complained that some non-court cases are not showing up on an 1160 report from DHHS until they have been open for several months. By the time the CAC is aware of the case's existence, it may be time to close the case.

Implications Continued

2. Challenges of the Multi-Disciplinary Team Meetings

Coming to a consensus about how non-court involved cases should proceed is another difficulty encountered during team meetings. At times, it can be difficult for case coordinators to find common ground between those who want to pursue a court filing and those who want to maintain non-court services.

Several CACs commented that for some counties, it can be difficult to get the appropriate team members to come to meetings on a regular basis.

Areas Needing Improvement

- *Data Collection and Documentation*
- *Challenges of the Team Meetings*
- *Lack of and Accessibility to Resources*

Many of the rural county teams served by the various CACs only meet once per quarter. These CACs noted that it can be difficult for the team to stay up-to-date on non-court involved cases. For example, a new non-court case may open immediately after the quarterly team meeting and close before the next one.

3. Lack of and Accessibility to Resources

CACs with multiple rural counties noted that it can be difficult to locate services for non-court involved families in these areas. These services include mental health and substance abuse treatment. In urban areas, there may be services available yet gaining access to them may be difficult due to volume.

Systems' Issue

New CFS Intakes During a Non-Court Case and/or After Case Closure

Some non-court involved families continue to be the subjects of CFS hotline calls, even when their cases are still open. However, these intakes may not rise to the level of a safety threat. The county attorney or DHHS may not have enough evidence for a court filing, but the concerns about these families remain.

Some CACs have also been tracking how many families receive new CFS intakes after their non-court cases have closed. One CAC noted that DHHS caseworkers are being pressured to keep their caseloads low, so they may be closing cases prematurely. This could result in families coming back into the CFS system after their non-court cases close.

Systems' Issue

- *New Intakes to the Hotline of the Non-Court Cases*

Recently, DHHS contracted with the state's Public Behavioral Health Network (Regions) for them to provide services to families with mental health issues. The Family Empowerment Program is an avenue available to high risk families who may not need CFS involvement. After the initial assessment is finished, their CFS case is closed and the Region provides services. Because these families are high or very high-risk for future maltreatment, CAC coordinators should be informed of them and they should be reviewed at team meetings in accordance with LB 993. Some CACs have struggled to receive information about families who are being referred to this program. Furthermore, there is some confusion as to which cases are being referred to the Regions and which are becoming non-court involved. The criteria for each type of case sometimes overlap. CACs will continue to work with DHHS in order to clarify the criteria and receive information about the families who are referred to the Family Empowerment Program.

Successes

Community Agencies Serving on Teams

Having multidisciplinary team members who are mental health professionals has been very helpful for some CACs. Their expertise on mental health issues and possible community resources for families has been invaluable.

Preventing Out-of Home Care

Many CACs commented that having a multidisciplinary team to review non-court cases has helped reduce the number of children in out-of-home care. Through team meetings, county attorneys have become aware of families who may be at a higher risk for future maltreatment. Instead of pushing for an immediate court filing, many county attorneys are willing to continue monitoring the families to see if a non-court intervention will work. One CAC commented that in its area, no non-court case went court-involved in six months.

Successes

- *Community Agencies Serving on Teams*
- *Preventing Out-of Home Care*
- *Teamwork and Communication*

Teamwork and Communication

Most CACs praised the multidisciplinary teams that review non-court involved cases. Specifically, they have observed improved communication and cooperation between the various agencies who serve on these teams.

Caseworkers who work with non-court involved families are becoming increasingly comfortable with presenting their cases to the teams. Some are even requesting that the multidisciplinary team review their non-court involved cases so that they can get feedback on possible services and ways to engage the families.

Through the past year, CACs and the professionals who serve on the non-court treatment teams have worked to create a system where non-court involved cases are being monitored. Although there are some areas that need to be improved, overall the CACs feel that this new system is working well.

"Information is freely being shared, and this process has only improved communication...at the beginning of this process there were a lot of reluctant team members and lack of communication, but now that a process has been put in place and is steadily running effectively, team discussion, open communication has only increased."

~MDT Team in FAN Service Area

A Closer Look at the Cases

In order to discover certain characteristics of families who become non-court involved, a statewide sample was reviewed with a total of 716 children represented in 289 cases. Table 2 summarizes the number of cases by each Child Advocacy Center's (CAC).

Sampling: 289 Non-Court Cases

TABLE 2. Location of Cases

Name and Location of Child Advocacy Center	# of Cases
Project Harmony (Omaha)	99
Lincoln Child Advocacy Center (Lincoln)	97
Northeast Nebraska Child Advocacy Center (Norfolk)	28
Central Nebraska Child Advocacy Center (Grand Island)	15
Family Advocacy Network (Kearney)	16
Bridge of Hope Child Advocacy Center (North Platte)	16
CAPstone (Scottsbluff)	18

A Closer Look...Families

ABUSE TYPES/FAMILY ISSUES

Overwhelmingly, physical neglect was the most common allegation. Table 3 summarizes abuse/neglect allegations. **Please note:** Some intakes had more than one allegation, so the total number of cases will exceed 289 cases.

TABLE 3. Abuse/Neglect Types

Abuse/Neglect Type	# of Cases
Physical Neglect	243
Physical Abuse	47
Sexual Abuse	15
Dependency	11
Emotional Abuse	9
Emotional Neglect	4

Additionally, N-FOCUS narratives regarding these cases were examined to determine if any adverse family issues existed. These issues are problems that could make the family more likely to be reported to CFS in the future. The most common adverse family issues are listed in Table 4.

TABLE 4. Adverse Family Issues

Adverse Family Issue	# of Cases
Domestic Violence	80
Dirty House	45
Improper Supervision	39
Poor Hygiene	30
Medical Neglect	22
Poverty	20
Educational Neglect	10
Prior Terminations of Parental Rights or Relinquishments	12

A Closer Look...Demographics

Family Demographics

The 289 cases in this sample included 716 children. Figure 8 provides a breakdown of how many children resided in each home.

- 205 cases (71%) had at least 1 child ages 0 to 5.
- 147 cases (51%) had at least 1 child ages 6 to 10.
- 96 cases (33%) had at least 1 child ages 11 to 18.

Primary caretakers ranged from 16 to 82 years old. The average age was 32 years old. Figure 9 shows that the most common age range was 26 to 35 years old.

FIGURE 8. Number of Children in the Home

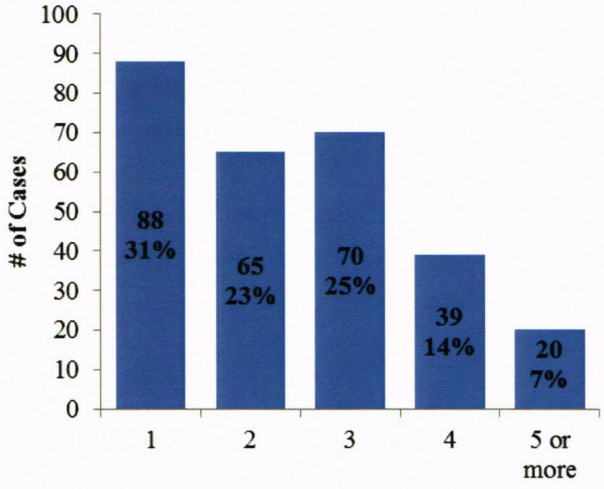
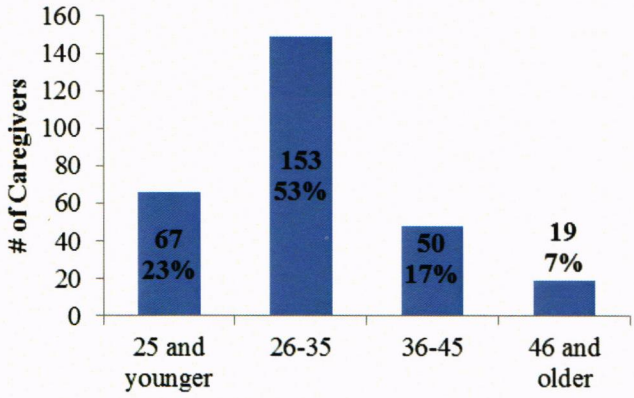


FIGURE 9. Age of Primary Caretaker



The racial/ethnic makeup of the primary caretakers was 68% white. The next most common group was Hispanic, followed by African American. The "other" race/ethnic category in Figure 10 includes American Indian/Alaska Native (n= 11), Multiracial (n= 5), Asian (n= 1), and Unknown (n= 10).

More than half of the sample cases had active Supplemental Nutritional Assistance Program (SNAP) benefits (food stamps). See Figure 11.

FIGURE 10. Race/Ethnicity of Primary Caretaker

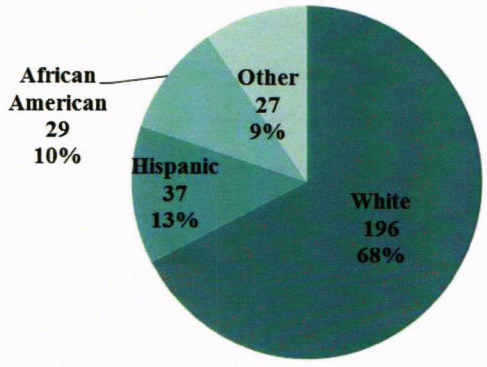
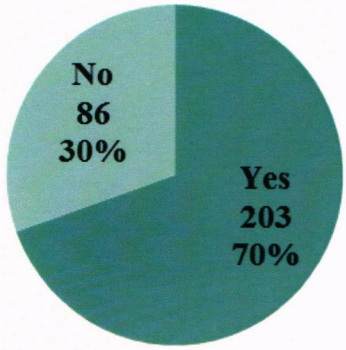


FIGURE 11. Active SNAP Benefits?

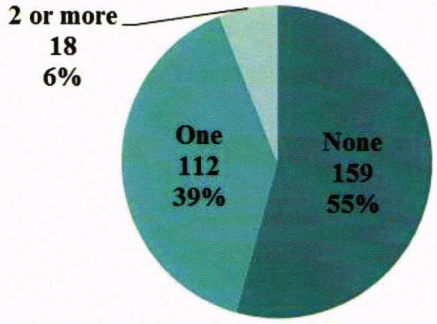


A Closer Look...History

Past CFS History

Almost half of families in the sample had a CFS substantiation prior to their current non-court case (45%). Figure 12 provides a summary of prior substantiations.

Figure 12. Number of Prior CFS Substantiations



Furthermore, Table 5 shows that 232 families (80%) had a CFS intake accepted by the hotline prior to their current non-court case. Families had a range of 0 to 22 prior accepted CFS intakes with an average of 3.

Table 5. Number of Prior Accepted CFS Intakes

# of Prior Accepted CFS Intakes	# of Cases	%
0	57	20%
1	44	15%
2-4	108	37%
5 or more	80	28%

A Closer Look...Caretakers

Mental Health Issues

As Figure 13 illustrates, 157 families had a caretaker who was diagnosed with a mental health issue. Table 6 shows that depression was the most common diagnosis, followed by anxiety-related disorders. **Please note:** Some caretakers had more than one diagnosis, so the total of Table 6 will exceed 157.

Figure 13. Caretakers with a Mental Health Issue?

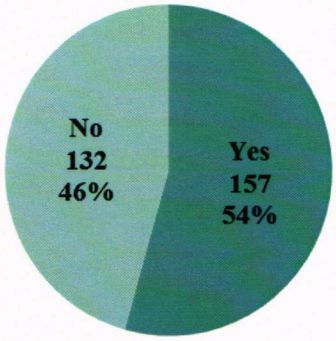


Table 6. Mental Health Diagnosis

Mental Health Diagnosis	# of Cases
Depression	91
Anxiety	71
Bipolar	51
Schizophrenia	11
Personality Disorder	5
Other	20

A Closer Look...Caretakers

Substance Abuse Issues

A total of 108 families had a caretaker who had a substance abuse issue (Figure 14). Table 7 shows that the most common drug of choice was methamphetamine, followed by marijuana and alcohol. **Please note:** Some caretakers had more than one drug of choice, so the total of Table 7 will exceed 108.

FIGURE 14. Caretakers with a Substance Abuse Issue?

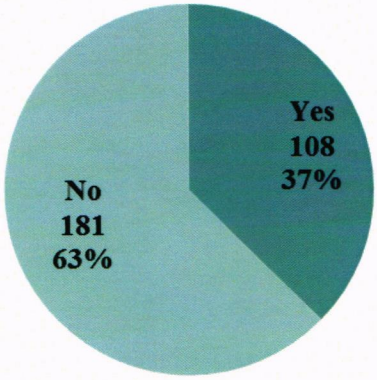


TABLE 7. Drug of Choice

Drug of Choice	# of Cases
Methamphetamine	43
Marijuana	40
Alcohol	35
Prescription Drugs	11
Other	4

53 out of 289 (or 18%) of the Primary Caretakers had been wards of the State at some time during their youth.

A Closer Look...Children

Mental Health Issues

Case records were also examined for possible mental health issues among the children living in each household. Figure 15 shows that 103 (36%) of the sample cases had at least one child with a mental or behavioral health issue. Many of these children do not have an official diagnosis, but worker observations and collateral contacts may confirm that they may need some type of mental/ behavioral health assistance. **Please note:** Some children had more than one issue, so the total of Table 8 will exceed 103.

FIGURE 15. Does a child in the family have a mental/behavioral health issue?

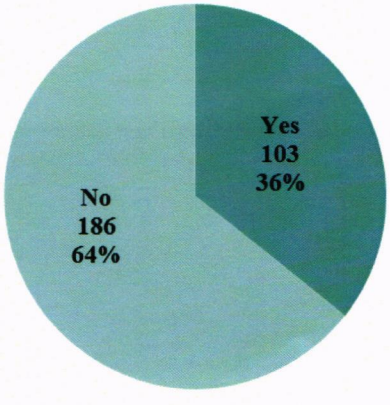


TABLE 8. Child's Mental/ Behavioral Health Issue(s)

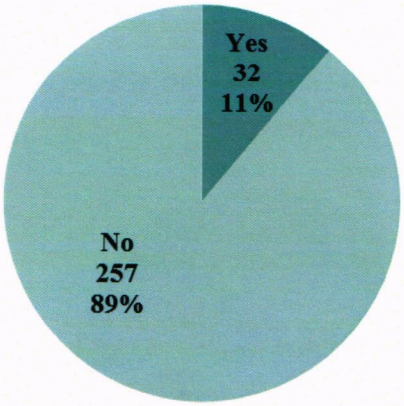
Child's Mental/ Behavioral Health Issue(s)	# of Cases
ADHD	60
Aggressive Behaviors	15
Anxiety	13
Oppositional Defiant Disorder	11
Bipolar	10
Depression	9
Other	27

A Closer Look...Case Outcomes

Court Filings

Figure 16 shows that a very small number of non-court involved cases received a court filing (*n*= 32, 11%). The overwhelming majority of cases closed without a court filing.

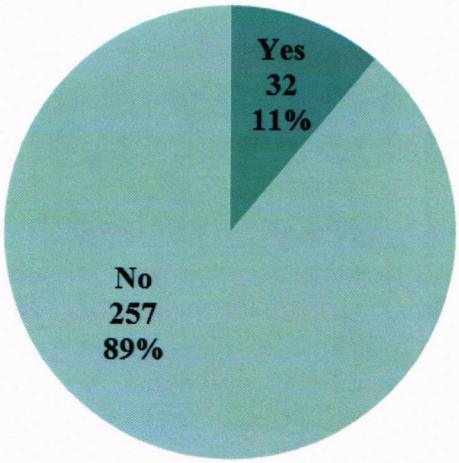
FIGURE 16. Number of Court Filings



New Intakes on Closed Cases

Similarly, only 11% of closed cases had a new accepted CFS intake after the case closed (Figure 17). **However,** it is important to note that many of these non-court cases closed only recently. Another evaluation of these closed cases will need to be done in order to see if this percentage increases over time.

FIGURE 17. Number of Cases that Received Accepted Intakes After Case Closed



What to Watch for in the Future

- *Tracking and Monitoring of Families Returning to the System*
- *Impact of Alternative Response*
- *Impact of Behavioral Health Expansion*

The Nebraska Alliance

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NE Alliance Staff and Contact Info:

Ivy Svoboda, State Chapter Coordinator
Nebraska Alliance of Child Advocacy Centers
11949 Q Street
Omaha, Nebraska 68137
(402) 595-1326
(402) 595-1329 fax
isvoboda@projectharmony.com
www.nebraskacacs.com

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Juvenile Services (OJS) Committee

Report to the Nebraska Children's Commission
October 16, 2013

Co-Chairperson: Ellen Brokofsky, Nebraska Children's Commission, State Probation Administrator – Administrative Office of the Courts and Probation

Co-Chairperson: Martin Klein, Nebraska Children's Commission, Deputy Hall County Attorney

Committee members:

- Kim Culp, Director -Douglas County Juvenile Assessment Center
- Barbara Fitzgerald, Coordinator - Yankee Hill Programs – Lincoln Public Schools
- Sarah Forrest, Policy Coordinator – Child Welfare and Juvenile Justice – Voices for Children
- Cindy Gans, Director of Community-Based Juvenile Services Aid – Nebraska Commission on Law Enforcement and Criminal Justice
- Judge Larry Gendler, Separate Juvenile Court Judge for Sarpy County, NE
- Kim Hawekotte, Director – Foster Care Review Office (former CEO – KVC Nebraska)
- Dr. Anne Hobbs, Director – Juvenile Justice Institute, University of Nebraska, Omaha
- Ron Johns, Administrator – Scotts Bluff County Detention Center
- Nick Juliano, Senior Director of Business Development – Boys Town
- Tina Marroquin, Lancaster County Attorney
- Mark Mason, Program Director - Nebraska Vocational Rehabilitation
- Jana Peterson, Facility Administrator – YRTC, Kearney
- Corey Steel, Assistant Deputy Administrator for Juvenile Services, Administrative Office of the Courts and Probation
- Monica Miles-Steffens, Executive Director – Nebraska Juvenile Justice association & Nebraska JDAI Statewide Coordinator
- Pastor Tony Sanders, CEO – Family First: A Call to Action
- Dalene Walker, Parent
- Dr. Ken Zoucha, Program Medical Director - Hastings Juvenile Chemical Dependency

Resources to the Committee:

- Sen. Kathy Campbell
- Sen. Colby Coash
- Doug Koebernick, Legislative Assistant for Senator Steve Lathrop
- Jerall Moreland, Assistant Ombudsman - Nebraska Ombudsman's Office
- Dr. Liz Neeley, Nebraska Bar Association, Supreme Court Minority Justice Committee
- Dr. Hank Robinson, Director of Research, Nebraska Department of Corrections
- Dan Scarborough,Facility Administrator – YRTC, Geneva
- Amy Williams, Legislative Assistant for Senator Amanda McGill

Meeting Dates:

January 9, 2013
February 12, 2013
March 12, 2013
April 9, 2013
May 14, 2013
June 11, 2013
August 13, 2013
September 10, 2013
October 8, 2013

Activities:

Strategic Planning and YRTC Evaluation:
The Juvenile Services (OJS) Committee met on October 8, 2013, to continue facilitated discussions on the requirements of LB 561. Joan Frances facilitated the discussion with assistance from Joyce Schmeeckle. The committee continued their work on drafting framework recommendations to add to the strategic planning efforts. The committee also discussed the future role of the Youth Rehabilitation and Treatment Centers in the juvenile justice system. The committee will meet on November 12, 2013, to review the draft report that is being created by Schmeekle Research Inc. from the committee's prior work. It is the intention of the committee that the finalized draft Juvenile Services (OJS) committee report will be delivered to the Nebraska Children's Commission for consideration at its November 19, 2013 meeting.

Department of Health & Human Services
DHHS
NEBRASKA

Kerry T. Winterer
Chief Executive Officer

State of Nebraska
Dave Heineman, Governor

October 1, 2013

Chief Justice Mike Heavican
Nebraska Supreme Court
State Capitol Building
PO Box 98910
Lincoln, NE 68509

Dear Chief:

Thanks for providing your thoughts about the importance of facilitated conferencing and mediation in juvenile cases. We do agree that this is an important service and, based on the San Francisco study, appears to be effective in appropriate circumstances to avoid litigation and create cost savings.

You raise concerns about the stability of funding for this service. Funding has come from the Promoting Save and Stable Families (PSSF) since 2009 when the first contract was entered into with the Department to provide these services. The amount of the first contract was $349,000 covering a period of 21 months. Since July 1, 2011 each fiscal year through June 30, 2013 has been funded in the amount of $235,000.

As we discussed at our meeting, it is difficult to know before October of each year how much the federal PSSF grant will be, but so far it has been a stable amount. Beginning this year we are moving the contract year for this program to an October 1 fiscal year to be consistent with the federal fiscal year and to know better the amount of the grant at the time the contract year begins. Apparently this year the program overspent its budget for the year ending June 30 which may have interrupted services, but we did amend the contract for the current quarter to provide one quarter of the $235,000 to bridge the gap to October so that ODR could provide current services.

The PSSF grant is the only source of funds for this program in the current budget. Although so far the amount has been stable, there are of course no guarantees from the federal government as to future funding. In the event grant funding is reduced for this program, we will do the best we can to find alternative funding sources, but, again, there can be no guarantees.

Please let me know if you have questions or would like to discuss this further.

Sincerely,

Kerry T. Winterer
Chief Executive Officer
Department of Health and Human Services

NEBRASKA SUPREME COURT

MICHAEL G. HEAVICAN
CHIEF JUSTICE

P.O. BOX 98910
STATE CAPITOL BUILDING
LINCOLN, NEBRASKA 68509
(402) 471-3738

September 18, 2013

Kerry Winterer, Chief Executive
Department of Health & Human Services
301 Centennial Mall South
Lincoln, Nebraska 68509

Dear Kerry:

At the Children's Commission meeting in August you heard a presentation by Judge Larry Gendler and Kelli Hauptman on facilitated conferencing and mediation in juvenile cases in Nebraska. Many efforts are being made statewide to increase the use of facilitation and mediation in child welfare cases. We think those efforts have been quite successful. Initial Pre-Hearing Conferences have increased from 200 to almost 700 per year over the past five years, and Permanency and TPR Pre-Hearing Conferences have increased from 20 to 108 in three years.

Nationwide, studies have shown facilitation and mediation in child welfare cases to be both effective and a cost-savings.[1] As Judge Gendler noted, a study from San Francisco found that sending one child welfare case to mediation every working day creates annual savings of $545,225 in avoided contested hearings. Avoiding litigious court practices is good for court and agency budgets and also good for the well-being of the families involved. My hope is that the use of facilitation and mediation in Nebraska will continue to grow and expand into juvenile justice cases, and that eventually an array of facilitated services can be provided at any stage in a juvenile case.

However, stability in funding has been and continues to be a barrier to increasing capacity and expanding use of facilitation into more cases. Repeated funding problems and delays have resulted in a reluctance on the part of some courts to use mediation. Relying on handouts from the Department of Health and Human Services creates an inherent impermanence that is incompatible with the plan to make facilitation and mediation common practice in the juvenile system.

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[1] National consensus also supports systemic use of mediation and facilitation. "All juvenile and family court systems should have alternative dispute resolution processes available to the parties. These include family group conferencing, mediation and settlement conferences. Excerpt from "Key Principles for Permanency Planning for Children." Technical Assistance Brief (1999). National Council of Juvenile and Family Court Judges, Reno, Nevada.

The use of facilitation and mediation is a proven method of resolving disputes, increasing family engagement and cutting down the time to permanent placement of foster children, and is cost-efficient. I strongly encourage you and the Children's Commission to support this practice by finding a permanent, stable way to support facilitation and mediation across Nebraska in juvenile cases.

Sincerely,

Michael G. Heavican

jmh

NEBRASKA CHILDREN'S CHAMPION INITIATIVE

OVERVIEW

Magellan is one of many stakeholders concerned about the increasing use of psychotropic medications in the behavioral treatment of children and adolescents. Our workgroup was formed a year ago to review the medical literature on this subject, and to propose strategies to educate all stakeholders in the appropriate and judicious use of medications in treating this population.

The workgroup also pulled together interventions in this area which were already underway across the company. Diverse efforts to address the issue of medications in children include: Medical Director participation in partner health plan P&T Committee meetings, best practice algorithm application in Enhance Med/Whole Health Rx, oversight of quality in prescribing through our QI program, as well as application of our clinical practice guidelines. Several Care Management Centers already had developed interventions to address this problem both in Magellan's public sector sites and in commercial sites.

In Nebraska, the Children's Champion program includes several interventions:

- Care Managers will receive training from the medical director on inappropriate prescribing of psychotropic medications in children. The Children's Champion webinar will be used, along with the clinical monograph as an educational tool to present this topic.
- Cases of potentially inappropriate prescribing will be indentified by the Care Manager, and will be reviewed by the Medical Director.
- If the prescribing is inappropriate, based on the information contained in the monograph, the Medical Director will reach out to the prescriber to educate regarding appropriate use of these medications.
- If possible, pharmacy claims data is obtained from MMA to confirm both the medication regimen, and alterations in the treatment plan based on the intervention.
- The MCO's will be offered training for their medical staffs and network on this issue, either by use of the webinar, or in person by the Medical Director.
- The monograph and its accompanying tip sheets will be presented by the senior clinical staff and/or corporate clinical resources to primary care professional groups across Nebraska either at hospital venues, or at their professional meetings such as the Nebraska Academy of Family Physicians and/or the Nebraska Academy of Pediatrics.
- Training for parents and other caregivers will be offered to local chapters of advocacy groups which will incorporate training on important questions to ask the prescribing provider before accepting medication intervention for a child.
- Metrics to be followed:
    - Number of cases identified with inappropriate prescribing
    - Numbers of interventions applied to each case
    - Alteration in inappropriate prescribing using pharmacy claims data
    - Number of cases that were diverted to psychosocial evaluations and psychosocial interventions as a result of the Care Manager/Medical Director interface
    - Number of primary care practitioners reached either individually, or through partnerships with hospitals and professional societies.
    - Number of parents reached through training offered through advocacy groups.

Nebraska Children's Champion Campaign

Background

In June of 2011, Magellan embarked on a comprehensive effort to lead the behavioral health industry in provider adherence to evidence-based and preferred practices for psychotropic prescribing to children and adolescents called the Children's Champion Initiative. The Children's Champion Campaign, led by our national clinical leadership, focuses on the overuse of psychotropic medications with children and adolescents. This initiative grew out of our awareness of alarming increases in the overuse and inappropriate use of psychotropic medications in these ages, fueled in part by unwarranted extrapolation of conclusions of adult drug studies to youth, direct-to-consumer advertising, and a trend to consider all behaviors biologically based. In current practice for this age group, there is general lack of diagnostic clarity and overuse of "NOS" (Not Otherwise Specified) diagnoses, and an increase in polypharmacy and "off label" medication use. These trends are cause for concern due to side effects that have significant potential for metabolic, cardiovascular, hormonal, and other biological disturbances; movement disorders; and known and unknown effects on the developing brain.

The Campaign is a structured program at every Magellan care management center, designed to collect data on provider prescribing patterns for children and adolescents, detect practices that fall outside of evidence-based or preferred practices, and modify those prescribing practices. Interventions include prompt care management response with Medical Director intervention as needed; systematic feedback to prescribers; PCP education individually and in group meetings and forums; parent and caregiver education; promotion of better coordination between prescribers and non-prescribers; and provider prescribing performance expectations codified in contracts.

Our focus on education and the development of tools has yielded *Appropriate Use of Psychotropic Drugs in Children and Adolescents: A Clinical Monograph* (Magellan Health Services 2013). An industry landmark, the monograph contains key information about the risks, benefits and side effects of specific medications when used in children. This information is essential for youth, parents, practitioners and other stakeholders. The monograph includes principles for best practice, a summary of current research, and guidelines for the use and monitoring of psychotropic drugs.

https://www.magellanprovider.com/MHS/MGL/providing_care/clinical_guidelines/clin_monographs/psychotropicdrugsinkids.pdf

www.magellanprovider.com go to "Provider" then "Providing Care" then "Clinical Guidelines" and finally "Clinical monographs" to access.

http://magellanpcptoolkit.com/ Organized by category, the materials in this PCP toolkit are designed to give medical practitioners the information and screening tools needed to assist in making behavioral health referrals. The toolkit represents our commitment to promote integration of medical and behavioral health services toward the goal of better overall outcomes for patients.

News Release

Psychotropic Drug Use in Children and Youth: Parents, Caregivers and Practitioners Must Understand Risks, Monitor Use

Release in PDF format

AVON, Conn.--(BUSINESS WIRE)-- Magellan Health Services (NASDAQ: MGLN), a leading specialty health care management company with expertise in managing behavioral health for approximately 34 million members — roughly 10% of the country's population — today said that the use of psychotropic drugs in children can be appropriate, but that parents, caregivers and practitioners must understand the risks, and monitor the use. Speaking to the anxiety and confusion that surrounds the prescription of these medications for children, Magellan released a clinical monograph on the subject, which also includes a first-in-industry summary of psychotropic drugs commonly prescribed for children, the FDA approval age, pediatric dosage level, and warnings and/or precautions, including "black box" warnings associated with their use. Only about 31 percent of psychotropic medications have been approved by the FDA for use in children or adolescents, and it is estimated that more than 75% of the prescriptions written for psychiatric illness in this population are "off label" — used for a purpose not listed on the label.

"This is a patient safety issue," said Gary Henschen, M.D., chief medical officer of Magellan Health Services Behavioral Health business unit. "The use of psychotropic drugs in children can be appropriate, but importantly, they must be used for therapeutic reasons and not simply for behavior control. The information in this clinical monograph clearly shows the risks and benefits of these medications that must be considered.

"Before medication is prescribed, a complete psychosocial evaluation must be performed to identify alternative therapies and approaches that may prove successful, and parents and caregivers need to ask questions to educate themselves about the medication and its side effects," said Henschen. "In addition, parents, caregivers and the child patient need to participate in all aspects of treatment decision-making, including the creation of a plan for use. For our part, we will continue to carefully monitor pharmacy claims data to help identify practitioners who prescribe outside best-practice norms, and provide consultation as to appropriate treatment options. Magellan is also committed to ensuring that parents, caregivers and the patient have the information necessary to make informed decisions."

Henschen continued, "The use of psychotropic drugs in children should be the beginning of the conversation, not the end, in terms of a full, broad, and wide-ranging treatment plan, particularly for those children in the Medicaid population who are more than twice as likely as their peers on private insurance to take an antipsychotic medication."

Pat Hunt, director of child and family resiliency services at Magellan Health Services, said that parents are often under pressure to make quick decisions about medication for their child.

"Some parents and caregivers seek medication as a result of demands from individuals who work in child-serving systems who are facing challenges in serving their child; some have tried other treatments and find themselves seeking medication as a last resort; and still others may be persuaded by their peers or advertising," said Hunt. "What they all share in common is their desire for a successful solution and a need to help their child. This resource can help familiarize parents, caregivers and practitioners alike with the risks associated with these prescription drugs, and help them ask questions, make informed choices and actively identify outcomes. Their role in monitoring medication and its effects is key to high quality clinical treatment."

"The use of psychiatric medications for children can be a useful tool in a multi-pronged treatment plan for children with emotional and behavioral health disorders. However, in many cases the use of psychiatric medications has outpaced the research that would support such use, particularly in young children," said Christopher Bellonci, M.D., an assistant professor at Tufts University School of Medicine. "As the scientific evidence base becomes more firmly established, resources like Magellan's clinical monograph are essential for parents, caregivers, and the youth themselves, as they try to navigate treatment recommendations."

Magellan has shared the monograph, "Appropriate Use of Psychotropic Drugs in Children and Adolescents," with the behavioral health practitioners in its network and is hosting a webinar to present the information to others in the industry.

About Magellan Health Services: Headquartered in Avon, Conn., Magellan Health Services Inc. is a leading specialty health care management organization with expertise in managing behavioral health, radiology, and pharmacy benefits programs, as well as integrated health care programs for special populations. Magellan delivers innovative solutions to improve quality outcomes and optimize the cost of care for those we serve. As of June 30, 2013, Magellan's customers include health plans, employers and government agencies, serving approximately 34.0 million members in our behavioral health business, 17.4 million members in our radiology benefits management segment, and approximately 9 million members in our medical pharmacy management product. In addition, the pharmacy solutions segment served 40 health plans and employers, 25 states and the District of Columbia, and several pharmaceutical manufacturers. For more information, visit www.MagellanHealth.com.

Magellan Health Services Inc.
Media Contact:
David Carter, 860-507-1909
DWCarter@magellanhealth.com

or
Investor Contact:
Renie Shapiro, 877-645-6464
RShapiro@MagellanHealth.com

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https://www.magellanprovider.com/MHS/MGL/providing_care/clinical_guidelines/clin_monographs/psychotropicdrugsinkids.pdf

Choosing Wisely®

An initiative of the ABIM Foundation

About

Share your feedback on the campaign

Choosing Wisely® aims to promote conversations between physicians and patients by helping patients choose care that is:

- Supported by evidence
- Not duplicative of other tests or procedures already received
- Free from harm
- Truly necessary

In response to this challenge, national organizations representing medical specialists have been asked to "choose wisely" by identifying five tests or procedures commonly used in their field, whose necessity should be questioned and discussed. The resulting lists of "Five Things Physicians and Patients Should Question" will spark discussion about the need—or lack thereof—for many frequently ordered tests or treatments.

This concept was originally conceived and piloted by the National Physicians Alliance, which, through an ABIM Foundation *Putting the Charter into Practice* grant, created a set of three lists of specific steps physicians in internal medicine, family medicine and pediatrics could take in their practices to promote the more effective use of health care resources. These lists were first published in *Archives of Internal Medicine.*

Recognizing that patients need better information about what care they truly need to have these conversations with their physicians, Consumer Reports is developing patient-friendly materials and is working with consumer groups to disseminate them widely.

Choosing Wisely recommendations should not be used to establish coverage decisions or exclusions. Rather, they are meant to spur conversation about what is appropriate and necessary treatment. As each patient situation is unique, physicians and patients should use the recommendations as guidelines to determine an appropriate treatment plan together.

Choosing Wisely Lists American Psychiatric Association

American Psychiatric Association

Five Things Physicians and Patients Should Question

Download PDF

1

Don't prescribe antipsychotic medications to patients for any indication without appropriate initial evaluation and appropriate ongoing monitoring.

Metabolic, neuromuscular and cardiovascular side effects are common in patients receiving antipsychotic medications for any indication, so thorough initial evaluation to ensure that their use is clinically warranted, and ongoing monitoring to ensure that side effects are identified, are essential. "Appropriate initial evaluation" includes the following: (a) thorough assessment of possible underlying causes of target symptoms including general medical, psychiatric, environmental or psychosocial problems; (b) consideration of general medical conditions; and (c) assessment of family history of general medical conditions, especially of metabolic and cardiovascular disorders. "Appropriate ongoing monitoring" includes re-evaluation and documentation of dose, efficacy and adverse effects; and targeted assessment, including assessment of movement disorder or neurological symptoms; weight, waist circumference and/or BMI; blood pressure; heart rate; blood glucose level; and lipid profile at periodic intervals.

2

Don't routinely prescribe two or more antipsychotic medications concurrently.

Research shows that use of two or more antipsychotic medications occurs in 4 to 35% of outpatients and 30 to 50% of inpatients. However, evidence for the efficacy and safety of using multiple antipsychotic medications is limited, and risk for drug interactions, noncompliance and medication errors is increased. Generally, the use of two or more antipsychotic medications

concurrently should be avoided except in cases of three failed trials of monotherapy, which included one failed trial of Clozapine where possible, or where a second antipsychotic medication is added with a plan to cross-taper to monotherapy.

3

Don't use antipsychotics as first choice to treat behavioral and psychological symptoms of dementia.

Behavioral and psychological symptoms of dementia are defined as the non-cognitive symptoms and behaviors, including agitation or aggression, anxiety, irritability, depression, apathy and psychosis. Evidence shows that risks (e.g., cerebrovascular effects, mortality, parkinsonism or extrapyramidal signs, sedation, confusion and other cognitive disturbances, and increased body weight) tend to outweigh the potential benefits of antipsychotic medications in this population. Clinicians should limit the use of antipsychotic medications to cases where non-pharmacologic measures have failed and the patients' symptoms may create a threat to themselves or others. This item is also included in the American Geriatric Society's list of recommendations for "*Choosing Wisely.*"

4

Don't routinely prescribe antipsychotic medications as a first-line intervention for insomnia in adults.

There is inadequate evidence for the efficacy of antipsychotic medications to treat insomnia (primary or due to another psychiatric or medical condition), with the few studies that do exist showing mixed results.

5

Don't routinely prescribe antipsychotic medications as a first-line intervention for children and adolescents for any diagnosis other than psychotic disorders.

Recent research indicates that use of antipsychotic medication in children has nearly tripled in the past 10 to 15 years, and this increase appears to be disproportionate among children with low family income, minority children and children with externalizing behavior disorders (i.e., rather than schizophrenia, other psychotic disorders and severe tic disorders). Evidence for the efficacy and tolerability of antipsychotic medications in children and adolescents is inadequate and there are notable concerns about weight gain, metabolic side effects and a potentially greater tendency for cardiovascular changes in children than in adults.

These items are provided solely for informational purposes and are not intended as a substitute for consultation with a medical professional. Patients with any specific questions about the items on this list or their individual situation should consult their physician.

The American Psychiatric Association (APA), founded in 1844, is the world's largest psychiatric organization. It is a medical specialty society representing more than 33,000 psychiatric physicians from the United States and around the world. Its member physicians work together to ensure humane care and effective treatment for all persons with mental disorders, including intellectual disabilities and substance use disorders. APA is the voice and conscience of modern

psychiatry. Participating in the *Choosing Wisely*® campaign furthers APA's mission to promote the highest quality care for individuals with mental disorders (including intellectual disabilities and substance use disorders) and their families.

For more information, visit www.psychiatry.org.

The American Psychiatric Association (APA) created a work group of members from the Council on Research and Quality Care (CRQC) to identify, refine and ascertain the degree of consensus for five proposed items. Two rounds of surveys were used to arrive at the final list: the first round narrowed the list from more than 20 potential items by inquiring about the extent of overuse, the impact on patients' health, the associated costs of care and the level of evidence for each treatment or procedure; and the second gauged membership support for the top five and asked for suggested revisions and comments. The surveys targeted the CRQC; the Council on Geriatric Psychiatry; the Council on Children, Adolescents, and Their Families; and the Assembly, which is the APA's governing body consisting of representative psychiatrists from around the country. After the work group incorporated feedback from the two large surveys, the APA's Board of Trustees Executive Committee reviewed and unanimously approved the final list.

For APA disclosure and conflict of interest policy please visit www.psychiatry.org.

Sources

1.

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Related Materials

- Additional information is available in the Resources section.

More patient-friendly materials are available from Consumer Reports at Consumer Health Choices.

510 Walnut Street, Suite 1700
Philadelphia, PA 19106