



PA juvenile offenders given psychiatric drugs at high rates

Psychiatric drugs flow at the state-operated secure youth correctional facilities, where chronic and violent juvenile offenders are sent. Are they drugged into behaving?

By Halle Stockton | PublicSource | Oct. 25, 2015

It's the end of the line for these kids. They've fallen through every safety net, and they keep making the same mistakes or more violent ones.

The kids — nearly all black or white teenage boys — are sent hours away from their families to youth correctional facilities, sterile lock-downs surrounded by barbed wire or cabins so far out in the wilderness they're considered secure even without a fence.

They are the toughest kids in the juvenile justice system. And, in some ways, the most vulnerable.

In the months they spend at correctional facilities, they receive mood-altering psychiatric medications at strikingly high rates, particularly antipsychotic drugs that expose them to significant health risks.

Psychiatric medications are prescribed to manage mental health and behavioral symptoms; antipsychotics are a type of psychiatric medicine approved to treat schizophrenia, bipolar disorder and irritability with autism.

Kids are more vulnerable to the severe side effects of antipsychotics — rapid weight gain and diabetes among them — yet doctors and juvenile justice experts told *PublicSource* they're confident the drugs are being used off-label in the state facilities to induce sleep or to reduce anxiety or aggression.

Some child advocates refer to this use as 'chemical restraint.'

Over a seven-year period, enough antipsychotics were ordered to treat one-third of the confined youth, on average, at any given time, according to a *PublicSource* analysis of drug purchasing information obtained from the Pennsylvania Department of Human Services, which operates the youth correctional facilities.

Only 1 to 2 percent of kids in the U.S. take antipsychotics.

"Most of antipsychotic use is likely for sedation and behavioral control" in Pennsylvania's youth correctional facilities, said Dr. Mark Olfson of the Columbia University Medical Center. Olfson is a leading research psychiatrist who reviewed the data *PublicSource* provided. "The new findings will hopefully spur much-needed institutional reforms."

Thousands of at-risk kids lived in six state-operated youth development centers and forestry camps from 2007 through 2013. Within the razor wire — or dense tree lines in forestry camps — psychiatric medications are flowing, despite the potential consequences to the developing brains and bodies of kids.

A recent study showed about one-fifth of foster-care youth in Pennsylvania were taking antipsychotics in 2012 — a finding that sounded alarm bells for the Department of Human Services (DHS), which commissioned the report.

The secretary of the department called the rates among foster children "disturbing" and "unacceptable."

PublicSource's look at the issue for the state's most troubled delinquent young people showed even more widespread prescribing, yet Human Services officials said they aren't encountering the same issues in the juvenile justice system.

The agency communicated with *PublicSource* almost entirely through email with responses approved by its legal department.

The department had weeks, and sometimes months, to respond to questions. Requests to interview DHS officials went unanswered for six weeks; an interview with Secretary Ted Dallas was scheduled and then abruptly cancelled. *PublicSource* shared its findings with the agency on Oct. 6.

The state also would not release the names of the doctors who are contracted to care for and prescribe to the youth, saying that it would compromise the safety of doctors if the facility residents had personal information on them.

A greater mental health need

Most of the kids are sent to the facilities after they've committed assaults, thefts and burglaries, or crimes related to guns and drugs. It is common for them to come from unstable homes or to roam with other kids who have had brushes with the law.

At its root, it is often a traumatic experience, one witnessed or committed, that drives their actions and can mimic mental illness.

PublicSource was not granted access to the facilities — one of which closed on Sept. 30. The centers are described by those who have visited as plain, with more the feeling of a hospital than a jail, but still with a maze of locked doors.

The state juvenile justice system takes youth ages 10 to 21; the state facilities saw youth 12 and 20 in the seven years studied.

For an average of seven to eight months, they're kept on a strict schedule for meals, schooling on the

premises, and some socializing in common areas with TVs and computers.

DHS Spokeswoman Kait Gillis wrote in an email that the department provides individualized health care to the juveniles with a multidisciplinary team that regularly monitors the effects of psychiatric medications, also called psychotropics.

She wrote that 44 percent of 266 residents in the facilities on Sept. 30 had a psychotropic medication prescribed by a psychiatrist. The department conducted a manual calculation on that day shortly after receiving additional questions from *PublicSource* on the matter.

Many enter the facilities with a psychotropic prescription, Gillis added, and some can be weaned off as they make progress with other non-drug therapies.

“The protocols we have in place actually lead to a reduction or termination of medication when possible,” she wrote. However, the state did not share whether it has any policies or controls on prescribing.

The department could not say how many enter with such a prescription, and the invoices provided by the department did not link the medications to specific cases or diagnoses because of privacy concerns.

PublicSource consulted several healthcare professionals and researchers to review the data, which took two years to obtain and turn into a usable database.

While the experts did see red flags pointing to potentially excessive or inappropriate prescribing in the state facilities, justice-involved youth are known to have a greater mental health need than the general population. Studies and experts estimate that between 50 percent and 75 percent have a diagnosable psychiatric disorder.

However, not every disorder calls for a medication and certainly not an antipsychotic.

Psychiatric medications can quickly improve an adolescent's' quality of life by alleviating depression or creating a clear mind. But many believe some prescribers overuse psychotropics, deploying them as a ‘silver bullet,’ rather than addressing underlying issues.

While the experts did see red flags pointing to potentially excessive or inappropriate prescribing in the state facilities, justice-involved youth are known to have a greater mental health need than the general population. Studies and experts estimate that between 50 percent and 75 percent have a diagnosable psychiatric disorder.

However, not every disorder calls for a medication and certainly not an antipsychotic.

Psychiatric medications can quickly improve an adolescent's' quality of life by alleviating depression or creating a clear mind. But many believe some prescribers overuse psychotropics, deploying them as a ‘silver bullet,’ rather than addressing underlying issues.

“The great concern among children’s advocates is that ... too often the medications are used to the benefit of the institution to control behavior in ways that are not appropriate,” said Robert Schwartz, co-founder and recently retired executive director of the Juvenile Law Center, a national public-interest law firm based in Philadelphia that brought the notorious “Kids for Cash” scandal to light in 2008.

The scandal netted two judges guilty of taking \$2.6 million in kickbacks to send youth to private for-profit centers and created demand for reforms to policies affecting youth in the state’s juvenile courts. Tools were adopted in many counties to assess mental health upon arrival at juvenile justice facilities, and the state began unshackling kids in courtrooms.

Psychotropic medications
alter brain chemicals to regulate mood and emotions.

Antipsychotics like Seroquel, Abilify and Zyprexa FDA-approved for youth with: Schizophrenia, bipolar disorder, irritability with autism Potential side effects: Sedation, weight gain, diabetes, nervous system disorder	Mood stabilizers like Depakote, lithium FDA-approved for youth with: Manic episodes, bipolar disorder, seizures Potential side effects: Weight gain, diarrhea, nausea, tremors
Antidepressants like Prozac, Zoloft and Paxil FDA-approved for youth with: Major depressive disorder, obsessive-compulsive disorder Potential side effects: Suicidal behaviors, weight loss, abnormal bleeding	Anti-anxiety like Vistaril (hydroxyzine) FDA-approved for youth with: anxiety, tension Potential side effects: Sedation, dizziness, dry mouth
Anti-ADHD like Adderall, Ritalin and Strattera FDA-approved for youth with: Attention deficit hyperactivity disorder Potential side effects: Growth delays, tics, decreased appetite, insomnia	

Source: Texas Department of Family and Protective Services and The University of Texas at Austin College of Pharmacy, "Psychotropic Medication Utilization Parameters for Children and Youth in Foster Care," September 2013
Graphic by Alexandra Kank / PublicSource

Quick fix

Antipsychotics, the most used of the psychotropics in the state facilities, are extremely powerful and effective.

That's why they're used so often in crisis.

The drugs are tranquilizing, instilling a quick calm. Some equate that calm to a stupor.

Dr. Terry Lee, a child and adolescent psychiatrist who treats residents of a Washington state-run secure juvenile correctional facility, said most antipsychotics used in correctional facilities are given to control disruptive behavior, like outbursts, aggression and breaking the rules.

"There aren't that many kids in juvenile justice facilities who are psychotic," he said.

Judge Kathryn M. Hens-Greco, who has heard delinquency cases for five years in the Allegheny County Court of Common Pleas, said she can't remember ever sending a kid diagnosed with schizophrenia or autism to one of the state facilities.

Some youth with behavioral health disorders, Olfson said, are likely receiving antipsychotics inappropriately.

"If they have schizophrenia or bipolar, hopefully they are not here but in psychiatric hospitals getting rehabilitated," he said. "I think their need for antipsychotics should make them ineligible for these facilities."

The American Psychiatric Association says poor and minority kids are more likely to receive antipsychotics for off-label reasons. The PolicyLab, a research entity of the Children's Hospital of Philadelphia, found 5 percent of Medicaid-enrolled children in Pennsylvania were taking antipsychotics in 2012.

It was prescribing among the state's Medicaid-enrolled foster children driving that rate.

Antipsychotics are quick to stabilize, but can also cause rapid weight gain that can lead to diabetes, metabolic syndrome and cardiovascular problems. It may lead to brain shrinkage and a shorter lifespan.

Even the U.S. Supreme Court has recognized that the brains of youth offenders are still developing when they took life sentences without parole off the table; so too, experts say, should state officials and doctors recognize they are taking a young person's future into their hands when they prescribe psychotropics — for better or worse.

Dr. Christoph Correll, a psychiatrist and scientist, published a study in 2009 linking antipsychotic use and weight gain in youth. The kids studied gained 10 to 20 pounds in fewer than three months, he said.

"Children and adolescents seem to be more vulnerable to these side effects," he said. "We need to improve the behaviors of the mentally ill with education and healthy lifestyle and go to low-risk interventions first."

Gillis, the DHS spokeswoman, wrote that all residents of Pennsylvania youth correctional facilities get a mental-health screening within one hour of arrival. The kids are further assessed by social workers, nurses, physicians, psychological services associates, counselors and psychiatrists, she wrote.

Other therapies offered include cognitive behavioral therapy, individual and group counseling and programs for anger management and substance abuse issues, she wrote.

"There are unique challenges as many of the residents have not had consistent access to preventive care or to a medical provider," Gillis wrote.

In the state facilities, the youth are provided a bill of rights, 22 liberties that include the rights to receive appropriate behavioral health care and to be free from excessive medication. The state contracts with the Mental Health Association in Pennsylvania to send in youth advocates. If medication questions come up, advocates refer them to a nurse.

Gillis wrote that kids prescribed certain psychiatric medications are monitored regularly through therapy, blood work and physical exams, and monthly updates are provided to the psychiatrist.

At the Washington state facility in which Lee works, he developed and implemented psychiatric practice guidelines. The guidelines include requirements to generally limit antipsychotic prescriptions to youth with psychotic and bipolar disorders; to prioritize skills training and non-drug therapy for disruptive behavior; and, when prescribing for sleep, to first use medications with more benign side effects, like melatonin or diphenhydramine (Benadryl).

Lee published a study on Oct. 1 in the journal *Psychiatric Services* that compared psychiatric medication costs and aggression levels at three secure juvenile facilities, including where he works.

The study, spanning 2003 to 2012, shows Lee's facility with psychiatric practice guidelines reduced its costs of psychotropic drugs by 26 percent, and incidents of aggression remained level. Costs for facilities without the guidelines doubled, and aggression levels increased, Lee said.

Psychotropic drugs dominated the medication budgets at the Pennsylvania youth centers, accounting for more than \$3.4 million of the \$5.5 million spent over seven years, according to the *PublicSource* analysis.

The state and counties pay for medications prescribed to residents of youth correctional facilities because Medicaid benefits are terminated or suspended when a juvenile is sent to one.

Seroquel (quetiapine) and Abilify (aripiprazole) — both antipsychotics — were two of the most ordered medications. About \$2.2 million was spent on these two drugs alone.

Psychotropic drugs dominated the medication budgets at the Pennsylvania youth centers, accounting for more than \$3.4 million of the \$5.5 million spent over seven years, according to the *PublicSource* analysis.

The state and counties pay for medications prescribed to residents of youth correctional facilities because Medicaid benefits are terminated or suspended when a juvenile is sent to one.

Seroquel (quetiapine) and Abilify (aripiprazole) — both antipsychotics — were two of the most ordered medications. About \$2.2 million was spent on these two drugs alone.

Rx pad

There has been no thorough examination in the state or nation on the prescribing of psychiatric medications to delinquent youth — an irony considering the momentous trend of jails and prisons, both adult and juvenile, filling the role of psychiatric facility.

With fewer resources and less training to cope with aggression, the mental health system over time has lost its ability to handle youthful offenders, and correctional facilities have become the default, said Ned Loughran, executive director of the Council of Juvenile Correctional Administrators.

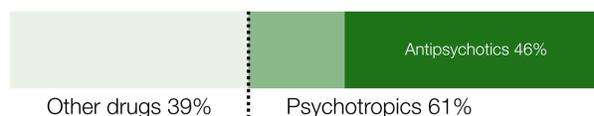
“The catch 22 is the more the youth correctional facilities respond to that and develop specialized programs because they have to deal with the youth, the more the courts are going to use them,” he said.

The majority of youth offenders in Pennsylvania are in private facilities. They are for the teens with lesser crimes, fewer problems and shorter stays. The chronic or violent offenders go to the youth development centers and forestry camps.

Drugs purchased for delinquent youth

The state purchased \$3.4 million worth of powerful psychotropic drugs for use at six youth development centers and forestry camps between 2007 and 2013. Of those purchases, about \$2.5 million were spent on antipsychotics.

\$5.5 million on all purchases



Source: Purchasing information provided by the Pennsylvania Department of Human Services
Graphic by Alexandra Kanik / PublicSource

The facilities have adapted, contracting with medical professionals who know how to treat depression, anxiety and attention deficit hyperactivity disorder (ADHD) with medications that also fall under the umbrella of psychotropics.

In addition to antipsychotic use in the six state facilities:

The antidepressants ordered were sufficient to treat more than 20 percent of the confined youth, on average, at any given time over the seven years studied. That includes the drugs Prozac and Paxil, which have been shown to increase suicidal behaviors in adolescents.

Mood stabilizers, like lithium used to treat manic episodes and bipolar disorder, were the next most used of the five drug classes analyzed. The prescriptions were sufficient to treat an average of 14 percent of residents at any given time.

Psychiatrists were surprised by the levels of anti-ADHD medications, which were ordered about one-third as often as antipsychotics. ADHD is likely one of the most prevalent disorders in the facilities, experts said. The orders were sufficient to treat an average of 9 percent of the youth at any given time.

Medications to combat anxiety were the least ordered of all the psychotropic classes, sufficient to treat an average of 6 percent of the juveniles at any given time.

It is also possible that some juveniles receive more than one psychiatric medication. It's called polypharmacy.

If one drug starts losing its power, the meds are often layered with others.

The American Academy of Child and Adolescent Psychiatry says polypharmacy should be generally avoided.

Once a medication is on the market, a doctor has free rein to prescribe it for all kinds of symptoms. Sometimes the evidence supports its use, and sometimes not.

Correll, a professor at Hofstra University's School of Medicine, advises using interventions with fewer side effects and rarely, if ever, trying antipsychotics off-label for sleeplessness, anxiety or ADHD. Alternatives can include anything from changing diet and sleep habits, to counseling, to other medication with fewer risks.

Finding clarity

Jennifer Drake is the national director of behavioral health services for Youth Advocate Programs (YAP), a Harrisburg-based nonprofit that provides community-based services to youth in 18 states and Washington, D.C., many of whom have been placed in corrections or foster care.

YAP has programs in 31 Pennsylvania counties and the city of Philadelphia.

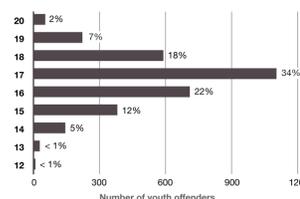
Drake remembered a teenage boy who had experienced multiple placements, with medications layered at every stop.

When he returned home, YAP's psychiatrist diagnosed him with depression. The boy was taken off antipsychotics and anti-ADHD drugs in favor of a mild antidepressant and counseling.

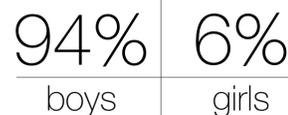
Who are these kids?

The youth who spent time in six state-operated juvenile correctional facilities from 2007 through 2013:

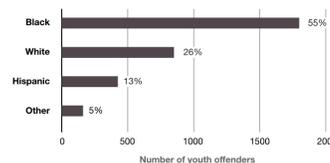
By age



By gender



By race



By county

Nearly 60% of facility residents came from three counties:



Source: Pennsylvania Department of Human Services
Graphic by Alexandra Kanik / PublicSource

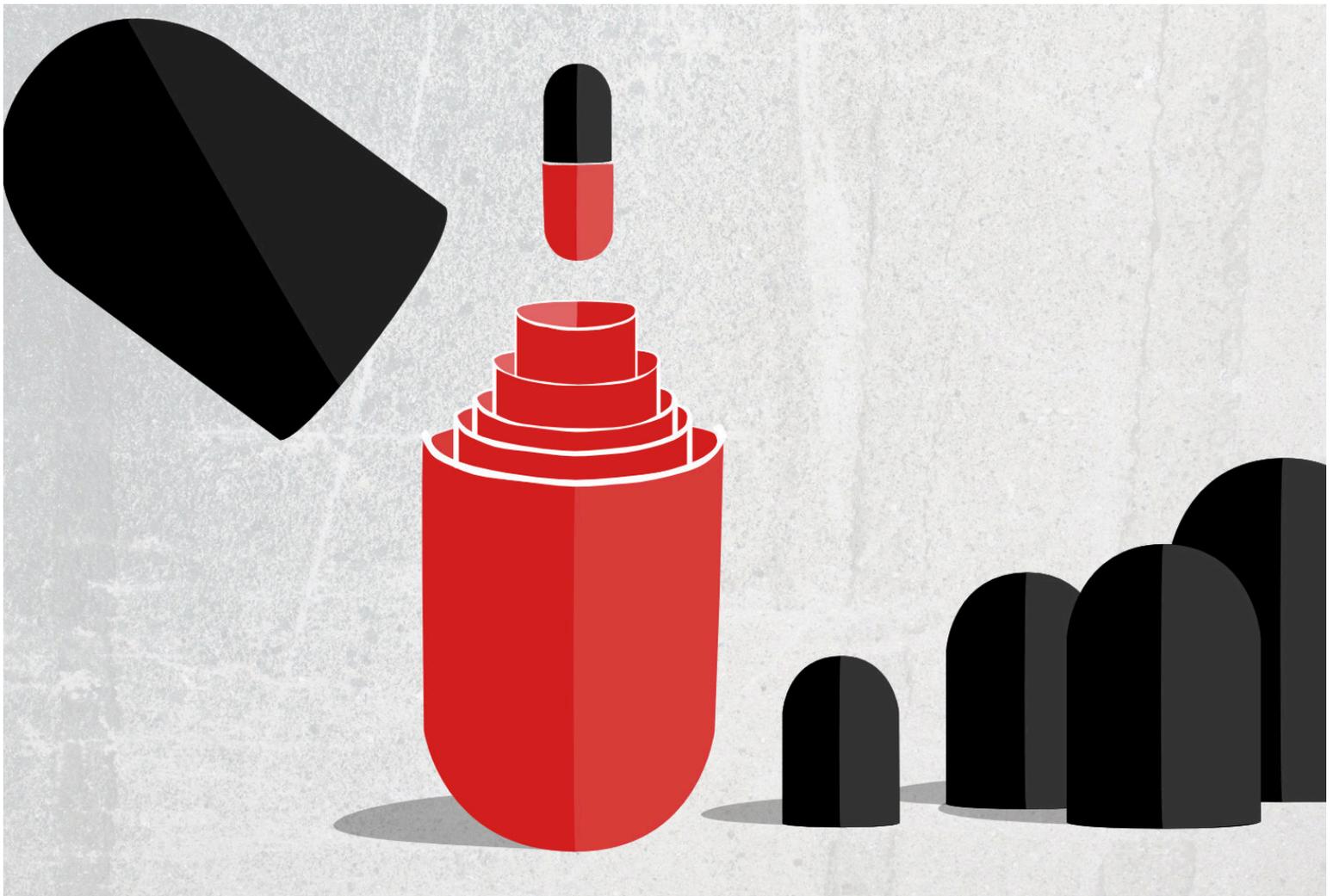
First, his headaches went away and he began to lose weight, she said. Then he started to break out of his shell and have conversations.

“I think all of us believe medication should only be one part of a child’s treatment,” Drake said. “They are certainly lifesaving and life-changing and many kids need them, but they shouldn't be the first line of treatment or the only treatment.”

Reach Halle Stockton at 412-315-0263 or hstockton@publicsource.org. Follow her on Twitter at @HalleStockton.

Data work by Alexandra Kanik, Eric Holmberg and Stockton.

Illustration by Anita Dufalla. Graphics by Alexandra Kanik.



Where's the oversight of psychiatric meds for PA youth offenders?

Other states have systems in place to track and control prescribing of powerful mood-altering medications.

By Halle Stockton | PublicSource | Oct. 28, 2015

Pennsylvania is lagging when it comes to tracking the powerful psychiatric medications kids get in the state's youth correctional facilities.

While other states have reformed the way they control and track such medications so that it is done systemwide, the Pennsylvania Department of Human Services follows only the total amount paid for the drugs prescribed in its six facilities on a systemic basis.

Everything else is looked at on an individual resident and facility basis. Experts and officials in other states say the fragmented approach reduces the department's ability to see patterns and to plan effective programs.

A *PublicSource* investigation found that psychiatric medications are being given at alarmingly high rates to the confined youth. The most powerful and risk-laden class of psychiatric drugs, the antipsychotics, was ordered in

amounts that could treat an average of one-third of those in the state facilities at any given time over the seven years studied.

Among concerns about the levels of prescriptions is that the drugs can have serious side effects and may be used to keep kids in line.

The rate of antipsychotics prescribed in the state's youth development centers and forestry camps is higher than that found for juveniles in foster care in Pennsylvania, where 22 percent were given antipsychotics in 2012, according to a study commissioned by the Department of Human Services (DHS).

The state and much of the nation is focused on stemming the high levels of psychiatric medications used in foster care.

But other states have realized kids in the delinquency system often come from foster care or similar backgrounds. They have begun scrutinizing medications prescribed to both populations through the courts and the departments that oversee the facilities. In addition to tracking the meds, they have also established controls on prescribing.

Experts see this as a crucial health matter for kids who are already slipping through the cracks.

Robert Schwartz, co-founder of the Juvenile Law Center in Philadelphia, said the state needs a way to track variations in prescribing by doctors and facilities, the degree to which parents are involved in making decisions about treatment, and the impact on kids, both foster and delinquent.

"It's pretty clear that we do not have that system today," he said of the state's methods.

Review

The high-security juvenile system has been shrinking in recent years as the state moves away from placing kids in the rural facilities and invests in more community-based services.

The five youth development centers and forestry camps still open have 370 beds, but only about 270 kids were residing in the centers or camps as of Oct. 14. The sixth included in *PublicSource's* analysis — the 52-bed Cresson Secure Treatment Unit in Cambria County — closed Sept. 30.

Thousands of young people, ages 12 to 20, spent time in the state facilities from 2007 through 2013. There were 606 beds in fiscal year 2007-2008.

The department wrote that information on medications is maintained in individual juvenile files and monthly invoices.

"We physically do not have the system to pull this," DHS Spokeswoman Kait Gillis told *PublicSource* in a May 2014 phone call about the records requested. "The only aggregates we keep is the amount of money spent that has to go into the budget for how much money we spend on prescriptions."

In a Sept. 26 email, Gillis wrote that "a review of medications and costs is conducted monthly by each health services site to monitor costs and quantity."

She wrote that the reviews entail someone at each facility looking at costs as well as the medications and quantities given to each individual for "treatment plan management."

The doctors and other health staff regularly monitor individual residents for how well medications are working and side effects, Gillis wrote.

Kid by kid

Melissa Sickmund, director of the Pittsburgh-based National Center for Juvenile Justice, leads several national data collection efforts on juvenile justice issues. Her job exists to collect and analyze data that can be used to make policy on state and federal levels.

Sickmund said the state could use aggregate data on prescribing to establish goals for the health care of all the kids they serve rather than only looking at each kid’s health issue in a silo.

“If you’re looking at one kid and one kid and one kid, you won’t even notice that you had that big jump, so you’re not ever going to ask yourself, ‘Why?’” she said.

The state would not discuss whether it has policies for prescribing psychotropics (a technical term for psychiatric medications).

PolicyLab, a research arm of the Children’s Hospital of Philadelphia, released the DHS-commissioned study on prescribing to the state’s foster kids in June. There are many more children in foster care than in the youth correctional facilities. PolicyLab identified 18,400 youth who were in foster care at some point in 2012.

The department responded to that study by saying it would create an “electronic dashboard” to monitor the use of antipsychotics in foster youth.

Also in response to the study of foster children, DHS said it would create a consultation hotline for physicians who prescribe psychotropics to children, improve assessment tools, and revise guidelines on treating children when parents cannot be reached in a timely manner to give consent.

Schwartz, of the Juvenile Law Center, said data collection of all kinds has put a strain on Pennsylvania state agencies, and it results in a lot of data not being collected at all.

“It’s not that it’s not doable, but it may be expensive,” he said. “It hasn’t been a priority, but many of us who work with kids think it should be.”

It has been a priority in other states, whose decisions could show the way to improve prescription monitoring for Pennsylvania juveniles.

In Colorado, a 2014 legislative audit of youth correctional facilities found high levels of psychiatric medication prescribed.

This July, Colorado’s Department of Human Services hired a medical director to oversee the use of psychiatric medications for both foster and delinquent youth.

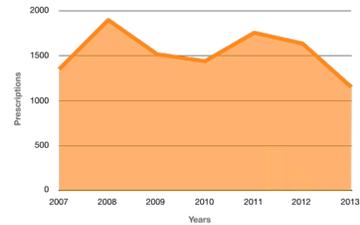
The Colorado General Assembly dedicated nearly \$745,000 to medical management oversight for this population, according to an email from Alicia Caldwell, the department’s spokeswoman.

Other groups and institutions that provide health care to children say that monitoring and data collection are crucial to running effective programs.

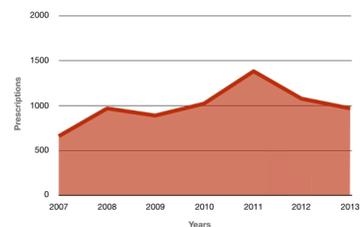
Hospitals use aggregate data to see what their clinicians are doing and to understand the population they’re serving, said

Psychotropic prescribing trends

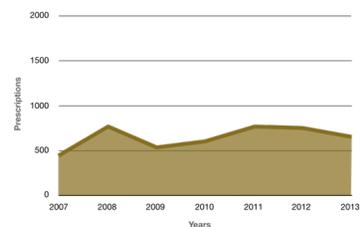
Antipsychotics



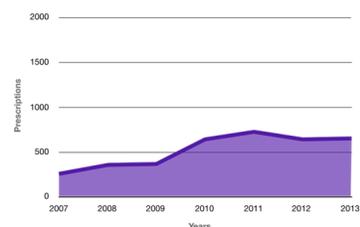
Antidepressants



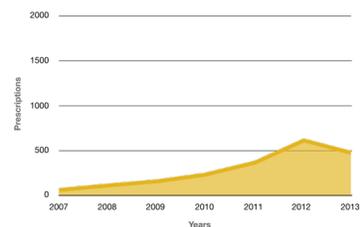
Mood stabilizers



Anti-ADHD medications



Anti-anxiety medications



Source: PublicSource analysis of state drug records
Graphic by Alexandra Kanik / PublicSource

Kathleen Noonan, founding co-director of PolicyLab.

“It helps you forecast where you’re going, and do you want to change?” she said.

Policies

In May 2011, the *Palm Beach Post* reported that Florida’s Department of Juvenile Justice didn’t track prescriptions or know why doctors were prescribing certain medications.

Around the same time, the department began considering a number of juvenile justice reforms, including prescribing practices. It has since become a leader in tracking and putting controls on medications in its juvenile justice facilities.

The state has electronic medical records in its detention centers that flag the use of psychotropic medications and allows health services to track and analyze them systemwide. The department is also implementing electronic medical records in its secure residential and correctional facilities, said Laura Moneyham, assistant secretary for residential services.

Since 2012, the department has conducted regular evaluations of psychiatric medication use. The Florida department shared with *PublicSource* its January 2014 findings broken down by program, region, drug type and other indicators. It showed 29 percent of the youth in the state’s various juvenile justice programs were on a psychiatric medication.

Moneyham said the department has not seen a “substantive change” in the percentage of kids on psychiatric medications since they began tracking.

Florida also codified existing policies in an administrative rule in June 2014, requiring prescribers to provide clinical justification in writing for the use of more than one psychiatric medication at a time and to obtain parental consent, verbal and written, every time a new psychiatric medication is prescribed, discontinued or changed.

The rule prohibits using psychotropic meds in an emergency to control behavior. It also says they can’t be used “as punishment, for staff convenience, discipline, coercion or retaliation.”

Texas has a similar policy in place, in which an independent review is triggered any time the medications are used in emergencies.

Judges’ roles

When Allegheny County Court of Common Pleas Judge Kathryn M. Hens-Greco began to hear juvenile dependency and delinquency cases years ago, she noticed kids showing up in her courtroom in what appeared to be a drugged haze.

Her concerns, which she raised at roundtable sessions of the Pennsylvania Supreme Court’s Office of Children and Families in the Courts, resulted in a workgroup. From 2011 to 2014, they evaluated the use of psychiatric medications among foster children.

Pennsylvania is more easily able to analyze prescribing for foster children because they are on Medicaid. Medicaid benefits are terminated or suspended when a youth is sent to a state facility.

“Without oversight, it’s a really bad problem for our kids,” said Hens-Greco. “With oversight, what we’re really asking is for people not to make the prescription pad the first choice of treatment.”

When a young person is sent to a correctional facility, it is not a sentence like you see in adult court; they are called commitments and the person’s time in the facility is up to interpretation, based on progress noted by caseworkers and judges at periodic review hearings.

The state workgroup developed a card for judges that provides questions for them to ask to help understand and regulate medication use among foster children and youth offenders.

Two years ago, the National Council of Juvenile and Family Court Judges, a Reno-based nonprofit with a mission to improve the family court system, adopted a resolution creating protocols for judicial oversight of these medications.

According to the resolution, judges are expected to seek out what is being prescribed and why, alternatives that have been tried and the effects of the medication. It also calls on judges to ensure that there is monitoring and that parents and children have been fully informed about the medications.

In California, the Welfare and Institutions Code requires court authorization for psychiatric medications. A physician must submit a request with the reason for the medication, the child's diagnosis, the goals of using the medication and a description of potential side effects.

The state's governor this month signed into law even stronger protections for kids seen in juvenile court by requiring more information on medications be submitted to courts and by training court officials to recognize overprescribing.

The policy is decidedly more generic in Pennsylvania, where judges are required to see that juveniles are receiving "necessary treatment and services," according to Keith Snyder, executive director of the Juvenile Court Judges' Commission (JCJC), a state agency that advises juvenile courts.

JCJC is providing judges with education on mental health treatment to better determine what is necessary in the treatment of mental health issues, Snyder said. Mental health was part of a weekend training for juvenile court judges in October, he added.

"We are going to be encouraging the judges to get more hands-on and not just trusting the treatment provider to do what we think is right," he said.

"We send kids to treatment programs, we expect them to get appropriate treatment, and now we need, I think, to pay closer attention to what's going on in these facilities and ask pointed questions to make sure these kids aren't being overprescribed."

Reach Halle Stockton at 412-315-0263 or hstockton@publicsource.org. Follow her on Twitter at @HalleStockton.

Data work by Alexandra Kanik, Eric Holmberg and Stockton.

Illustration and graphics by Alexandra Kanik.



State won't disclose names of doctors prescribing in youth corrections

The Pennsylvania Department of Human Services says the safety of the doctors around juvenile offenders would be compromised.

By Halle Stockton | PublicSource | Nov. 1, 2015

The state defied an Office of Open Records ruling and took the matter to court to conceal the names of doctors prescribing to kids confined in its six correctional facilities.

The Pennsylvania Department of Human Services insisted the physicians who care for and prescribe to the state's most chronic or violent youth offenders would be endangered if their names were made public.

PublicSource requested the names of the doctors with whom the state contracts to determine their qualifications, disciplinary history and if they're taking payments from drug companies.

The request was part of a larger investigation that showed worrisome rates of psychiatric medications prescribed to the residents of the state's secure youth development centers and forestry camps. Experts say the meds, some of which carry severe health risks, are being used to drug the kids into behaving.

The kids can be dangerous. Most who end up in the rural centers and camps have been in court time and time

again. Many have handled guns and drugs; assaults and robberies are among the most common offenses.

But others who work with the same kind of kids found it troubling that there was so much concern over keeping the doctors anonymous.

Dr. Terry Lee, a child and adolescent psychiatrist to adjudicated delinquents in Washington state, said it's not a good sign.

"Shouldn't it be public knowledge that public dollars are going to someone?" he said. "Shouldn't you be able to track if they've had actions on their medical license?"

Lee also works in a secure juvenile correction facility, called the Echo Glen Children's Center, about 30 miles outside of Seattle.

"I'm not fearful. I tell people where I work," he said. "They may have very good reasons, but it just doesn't quite sound right."

'Detrimental'

The doctors are the "gateway" to medications. They also have a say in how long the kids, mostly teenagers, stay in the facilities.

Judges sometimes call on physicians and psychiatrists to evaluate their progress, and that can lead to either a release or waiting months before another review hearing.

The Department of Human Services (DHS), which operates the youth correctional facilities, said most doctors only use their last names during appointments with the juveniles.

The department would not release their full names because they say it would expose them and their families to the risk of physical harm.

"We have a major personal security issue with that," DHS Spokeswoman Kait Gillis said in a May 2014 phone call about the records requested. "The doctors disclose no personal information to these students. They receive a lot of threats on their physical safety. It would be really detrimental to them to have their personal information disclosed."

The department repeatedly refused to share the names of the current doctors and psychiatrists, despite the state Office of Open Records ruling that they should be released.

The Open Records office wrote the department did not provide "evidence showing a nexus between the release of the doctors' *names* and a risk of harm."

It also pointed out that the names of public employees are generally part of the public record.

"Here, the doctors at issue receive taxpayer money to perform services for the department, and without disclosure of these names, taxpayers cannot find out the ultimate recipient of this money."

The department petitioned the Commonwealth Court of Pennsylvania in February 2014 to review the Office of Open Records' ruling. In June 2014, the court selected the case for mediation.

Before the mediation process could start, the department offered to redact pharmaceutical invoices it previously argued were not public record if *PublicSource* withdrew its request for doctors' names.

PublicSource agreed to the compromise so that the project could move forward.

The invoices were used to analyze what prescriptions the kids were actually being given.

The danger

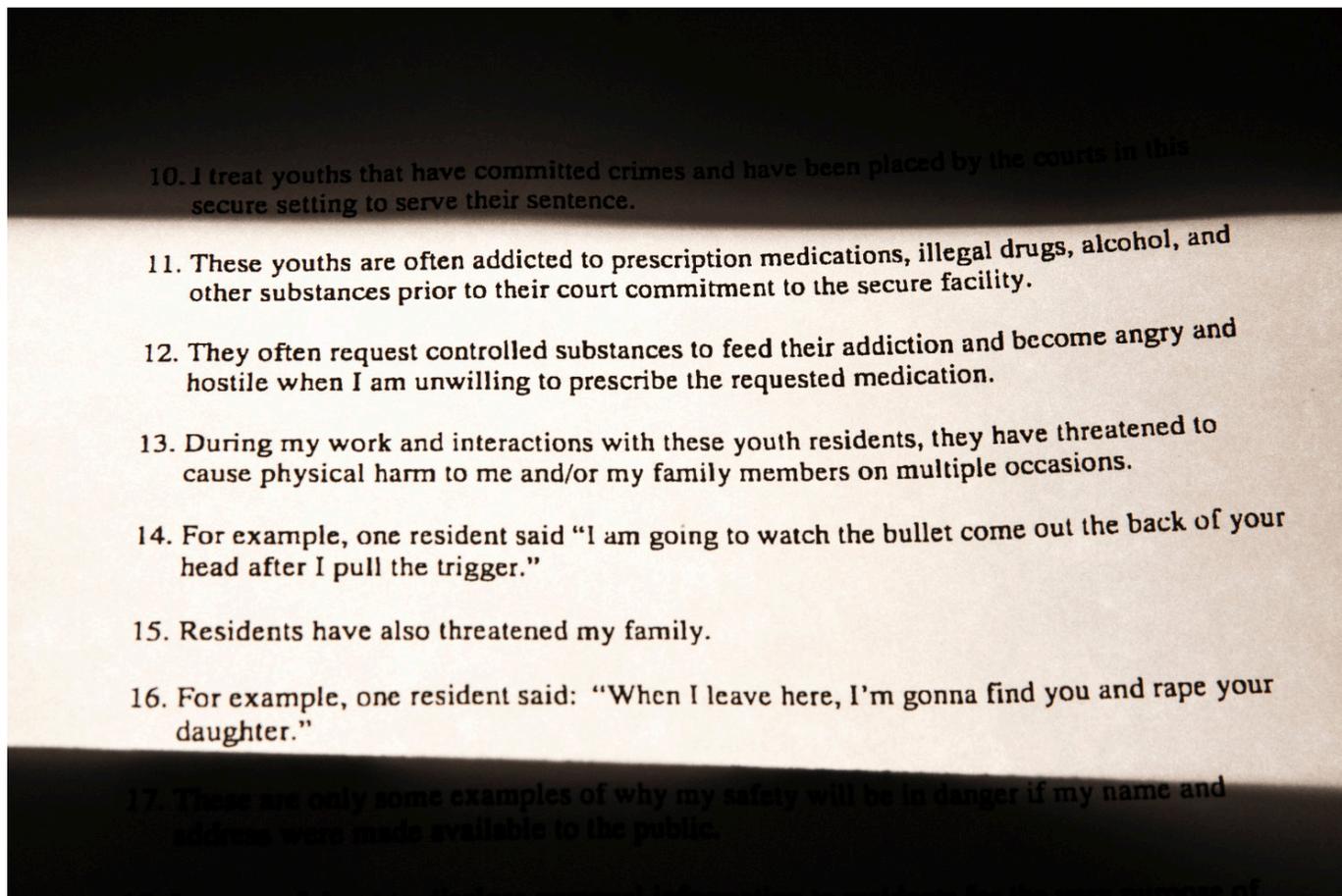
The youth residents were described as threatening, retaliatory and manipulative by the department and doctors.

One physician who had worked in one of the facilities for three years at the time said he fears his name being released to the media would lead to the troubled teens, their family members and gang associates to learn his full name and home and office address.

“Because many such persons have violent proclivities, my personal security and the personal security of my family and my neighbors would be placed in heightened jeopardy,” according to the doctor’s affidavit.

The doctor said residents have threatened to rape his daughter and to shoot him.

The physicians attributed substance-abuse issues among the youth as a point of tension. According to affidavits, the residents often request controlled substances and get hostile or make false complaints when denied.



An excerpt of a doctor's affidavit submitted by the Pennsylvania Department of Human Services in open-records correspondence. (Photo by Natasha Khan/PublicSource)

Another clinician, whose done this work for 12 years, wrote: “The youths are observant and attempt to find out personal information to use against me and my co-workers.”

The affidavits were submitted to the Open Records office by DHS with the doctors’ names redacted, and the state declined all requests for interviews.

Advanced Correctional Healthcare provides medical services at adult and youth facilities in 17 Midwestern states. Deborah Ash, vice president of compliance, said their doctors also only share their title and last name for safety reasons.

“It is still fairly easy to find them even with just a last name,” she said, “but you do the best you can do short of changing your name.”

The company also discourages the use of doctor-specific parking spots to prevent inmates’ families or gang associates on the outside from tracking them down.

Residents of the Pennsylvania facilities have proven to be dangerous at times.

According to *The Daily Item*, a resident of the North Central Secure Treatment Unit in October 2014 punched a staff member after a search of his room; the young man pleaded guilty to the assault in February.

In 2011, three teenagers were charged with attacking a guard at the South Mountain Secure Treatment Unit, according to a *Public Opinion* article.

Six staff members were injured in what was called a riot, started by four residents at the Cresson Secure Treatment Unit on Jan. 1, 2015, according to the *Pittsburgh Post-Gazette*.

PublicSource could not locate any accounts of incidents specifically targeting medical staff, and the department did not identify any in their arguments.

Prescribing pressures

Doctors taking money from drug companies is an inherent conflict of interest, especially when doctors are treating vulnerable kids in institutions where parental consent isn’t always obtained.

The 2010 Affordable Care Act established a federal rule that pharmaceutical companies must disclose what gifts, speaker fees and other payments doctors receive from them.

In Florida, the *Palm Beach Post* found that one in three psychiatrists contracted by the Department of Juvenile Justice over five years — 2007 to 2011 — had taken speaker fees or received gifts from pharmaceutical companies.

There was at least one obvious instance of a doctor who increased the prescribing of a certain medication at the same time he was paid by the maker of the drug.

The reporters were able to assess this because of Florida’s broad public records law.

Amanda Fortuna, a spokeswoman for the Florida department, told *PublicSource* that although a list of the doctors is not readily available, their names would not be exempt from the public record.

Pennsylvania doctors received about \$143 million from drug and medical device companies from August 2013 to December 2014; only five states had doctors taking more money, according to ProPublica’s Dollars for Docs app.

Meredith Matone, a research scientist for PolicyLab at the Children’s Hospital of Philadelphia, said the prescribing habits of individual doctors isn’t a driving factor in the overall issue of psychotropic medication use.

“There’s a small portion of providers who are probably skewed for their own personal gain,” she said.

For most prescribers, she said, they simply use the medications more once they are educated about them. “They may just look at it as another tool in their toolbox.”

But who’s supervising how they use those tools?

Gail Wasserman, a child psychologist who directs the Center for the Promotion of Mental Health in Juvenile Justice, said it can be particularly challenging to supervise doctors who are contracted to provide services.

“Healthcare is like a cyst to a facility, and it’s got to have its own supervisory structure,” she said. “Where is that, who does that and how do you make sure it works and it’s accountable?”

The Department of Human Services did not answer several questions posed by *PublicSource* on the checks and balances for its doctors.

‘The right to know me’

As a judge who has dealt with delinquent youth face to face for more than five years, Allegheny County Court of Common Pleas Judge Kathryn M. Hens-Greco could not relate to the doctors’ fears.

“Well, I would say the youth know my name pretty clearly. It’s on the bench. It’s on the order,” she said. “I don’t spend a lot of time worrying about my personal safety. I pay attention a little, but they have the right to know me. I am the one sending them to where they’re going.”

Hens-Greco said she is bothered that the doctors’ names were not released. She could only surmise that it is difficult to attract psychiatrists to the rural facilities, and the state felt they must honor their wish to remain anonymous to retain their services.

Sidney Ornduff, a psychologist in the Memphis area, evaluated hundreds of kids annually as director of clinical services for the Juvenile Court of Memphis and Shelby County for nearly five years.

She was torn when she heard about the state’s decision to withhold the doctors’ names. She said she has been threatened and scared by delinquent youth and their families before. She also said she felt the public has a right to know if the doctors are qualified and in good standing with their professional boards.

“Safety first, yes, but a degree of transparency,” she said.

The importance placed on the anonymity of the psychiatrists was upsetting to Dr. Melisa Rowland, a child and adolescent psychiatrist who is working with New York City’s juvenile justice system to implement Multisystemic Therapy, a model that works with chronically violent youth within their homes and communities.

“If they really feel that way, that’s probably part of the problem,” she said. “One thing that drives me crazy in my field is they act like they’re sociopaths. I’ve just worked with so many hundreds and hundreds of these kids ... I can’t remember the last time I came across a kid that was scary.”

Reach Halle Stockton at 412-315-0263 or hstockton@publicsource.org. Follow her on Twitter at @HalleStockton.

Illustration by Anita Dufalla.

About the data

The records

PublicSource made its first request for information regarding medications prescribed to juvenile offenders in the six state youth correctional facilities in October 2013.

The Pennsylvania Department of Human Services denied the requests. The department said the medication information was kept in individual juvenile files and invoices that contained private health information. That meant the files were not public records, they said, and there was no requirement to redact the identifying information.

The department also refused to share the names of the doctors, citing several exemptions in the state's open-records law but stressing that the release of the doctors' names would put them in danger.

PublicSource appealed to the state Office of Open Records, which agreed with the denial of medications information. The office did order the release of the names of doctors who were under contract to provide services in the state-operated youth development centers and youth forestry camps.

The department appealed to the Commonwealth Court of Pennsylvania, which selected the case for mediation. Before mediation, the department called PublicSource to negotiate.

An agreement was struck for PublicSource to withdraw its request for the doctors' names in exchange for seven years of invoices that show the medications ordered by the facilities.

In July 2014, PublicSource received a bankers box of about 4,000 pages of monthly invoices for each of the six facilities for the years 2007 through 2013.

The information on the scanned paper records was entered by freelancers into a database structure created by PublicSource. The digitized records were then sent to a data entry firm to audit the database for accuracy. PublicSource also conducted integrity checks on the data throughout the process.

The database includes drug name, drug dosage, the unit (such as mg, ml), medicine form of the drug (such as tablet, injection), which facility ordered it, how many units were ordered and the cost of the drug purchase.

We used a tool developed by the National Library of Medicine, called RxMix, to standardize drug names and classify into type of medication (antipsychotic, antacid, anti-inflammatory, etc.).

Focus and methodology

The five classes we focused on were: antipsychotics, antidepressants, mood stabilizers, anti-ADHD and anti-anxiety medications.

We performed additional data quality checks after running the data through the RxMix tool.

We removed certain non-drug entries that produced errors. For instance, purchases like an "Ace bandage," a simple elastic bandage used to restrict the movement of a sprained ankle, was misidentified as a "transdermal patch," an adhesive patch that, when applied to the skin, delivers drugs into the system.

We also removed any records that did not have enough information to be processed in RxMix.

With the help of the Institute for Nonprofit News, we used a program called Django as an interface for analyzing and eventually displaying our data.

PublicSource consulted with two leaders in the field of psychotropic medication use in children and adolescents to develop our methodology. They were:

Dr. Mark Olfson, professor of psychiatry at Columbia University Medical Center and a research psychiatrist for the New York State Psychiatric Institute, and

Dr. Christoph Correll, a professor of psychiatry at Hofstra University's School of Medicine and medical director of the recognition and prevention program at the Zucker Hillside Hospital.

At their advice, we treated purchases as monthly prescriptions. We compared this to the average occupancy over time, provided by the Department of Human Services, for each facility.

We used polypharmacy rates found among the state's foster children by PolicyLab of the Children's Hospital of Philadelphia - and supported by journal studies and medical experts - to account for when a juvenile might be on two antipsychotics or two antidepressants.

However, the analysis could not estimate polypharmacy across drug types. For instance, it is common for an antipsychotic to be added to an antidepressant to improve its efficacy.

Applying the polypharmacy rates reduced the percentage of youth offenders who could be treated at any given time. For instance, the antipsychotic prescriptions would have been sufficient to treat an average of 38 percent of the juveniles before the adjustment for polypharmacy. When we factored in juveniles who could be prescribed more than one antipsychotic, the average dropped to 33 percent.

To better understand our findings and to continue to ask important questions of the data, PublicSource also conducted about 40 interviews with judges and attorneys, medical experts and researchers, advocates, and state officials.

Limitations

While PublicSource attempted to obtain the most accurate data it could on the medications prescribed to juveniles in the youth development centers and forestry camps, there are some important caveats about the findings.

Misclassifications: The RxMix API was developed by the National Library of Medicine to be used as a tool to normalize and classify drugs. The system takes in dirty information - misspellings, abbreviations, improper dosages - and attempts to output cleaned, normalized, accurate drug information. Every attempt was made to ensure proper RxMix processing, but there may be certain records that were misclassified.

Assumptions about prescribing: Due to health privacy laws, the medications were not linked to any particular case or individual. PublicSource had to make certain educated assumptions about the prescribing habits at the facilities, which we detail in the methodology above. We made every effort to report a conservative estimate of psychotropic medication use.

Acknowledgements

PublicSource would like to thank:

Drs. Olfson and Correll for sharing their time and medical expertise;

Olivier Bodenreider at the National Library of Medicine, for his assistance with the tool that allowed us to actually use the data, and;

Ryan Nagel, Adam Schweigert, Ben Keith, Kaeti Hinck and Dani Litovsky at the Institute for Nonprofit News for their help in designing and developing the app.

Contact Halle Stockton at hstockton@publicsource.org or 412-315-0263.

Stories by Halle Stockton. Data analysis by Alexandra Kanik, Eric Holmberg and Stockton. App development by Kanik with help from the Institute for Nonprofit News. Graphics and charts by Kanik. Videos by Ryan Loew. Illustrations by Anita DuFalla.