FOLLOW-UP ASSESSMENT OF PSYCHOTROPIC MEDICATION MANAGEMENT AT THE YOUTH SERVICES CENTER AND NEW BEGINNINGS YOUTH DEVELOPMENT CENTER

Report 2024 – 1

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ATTACHMENT 1

I. Introduction

In 2023, the Office of Independent Juvenile Justice Facilities Oversight (OIJJFO) published a report titled "Comprehensive Medical Assessments, First Dose Administration, and Psychotropic Medication Management at the Youth Services Center and New Beginnings Youth Development Center."[1] This report included the results of an evaluation of medical assessments and services by Michael Cohen, MD,[2] as well as a review conducted by the OIJJFO of the Department of Youth Rehabilitation Services' (DYRS) compliance with its policies governing the use of psychotropic medication.

In the report, OIJJFO noted that between October 1, 2021 and June 30, 2022, the use of psychotropic medications was high at the Youth Services Center (YSC) and New Beginnings Youth Development Center (New Beginnings), with 17 percent of youth housed at the YSC and 66 percent of youth housed at New Beginnings prescribed one or more psychotropic medications.[3] Given the risks associated with the use of psychotropic medication,[4] the OIJJFO at that time reviewed a sample of youth prescribed one or more classes of psychotropic medication from each facility to determine if the prescribing practices were consistent with DYRS policies governing the use of psychotropic medications[5] as well as DYRS's Psychiatric Medication Monitoring Parameter (PMMP).[6] OIJJFO's review found that while baseline and ongoing monitoring of youth prescribed psychotropic medication had improved relative to 2019 practices,

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[1] *See* Report 2023-1, Comprehensive Medical Assessments, First Dose Administration, and Psychotropic Medication Management at the Youth Services Center and New Beginnings Youth Development Center (Report 2023-1) dated February 16, 2023.
[2] Dr. Cohen served as a medical consultant to the Special Arbiter in Jerry M.
[3] *Id.* at 33.
[4] *Id.* at 6.
[5] Medication Management, policy no. V.d.2., eff. January 17, 2018 (Medication Management Policy).
[6] Psychotropic Medication Monitoring Parameter, Department of Youth Rehabilitation Services, July 2018.

there remained critical gaps, particularly with respect to the ongoing monitoring of youth prescribed psychotropic medication.[7]

Given the findings described in the 2023 report, the OIJJFO elected to review again DYRS' fidelity to its Medication Management Policy and its PMMP governing use of psychotropic medications.[8] This report summarizes the findings of its latest review and includes recommendations that are designed to improve performance in meeting policy and PMMP requirements. A draft version of this report was provided to DYRS for review and comment on June 18, 2024. DYRS representatives submitted their comments on July 10, 2024, and a copy of those comments is attached to this report.[9]

II. Methodology

To assess whether DYRS is appropriately and consistently implementing the PMMP and Medication Management Policy, OIJJFO obtained data regarding all medications prescribed to youth housed at the YSC and New Beginnings between September 1 and December 31, 2023.[10] From that data, every prescription for psychotropic medications was identified and each

[7] *See* Report 2023-1 at 36-48. In 2019, the Special Arbiter reviewed compliance with the Jerry M. Work Plan requirements related to use of psychotropic medication, and found that DYRS was not meeting the Work Plan requirements nor its policies relating to baseline testing and ongoing monitoring of youth prescribed psychotropic medications. The 2022 review conducted by OIJJFO included a reassessment of some, but not all of the issues covered in the Special Arbiter's 2019 report.

[8] During the current review, OIJJFO also requested any updates to the Medication Management policy and the PMMP that that were in effect during the review period of September 1, 2023 to December 31, 2023. OIJJFO was informed that while revisions to the Medication Management policy were contemplated they had not yet been finalized. Similarly, no changes to the PMMP were reported. Therefore, OIJJFO utilized the standards set out in the 2018 Medication Management policy and PMMP in conducting this review.

[9] Attachment 1, July 10, 2024, Memorandum from Sam Abed, DYRS Director, to Mark Jordan, Executive Director, OIJJFO.

[10] Janet Maher assisted in the analysis of youth health records and production of this report. Ms. Maher is an attorney with extensive experience in institutional and health-care settings. She led the Office of Corporation Counsel's Mental Health Division from 1992 to 2000, operated as Deputy General Counsel and Chief of Staff for the District's Child and Family Services Agency from 2000 to 2007, served as a DOJ Compliance Officer at Saint Elizabeths Hospital from 2007 to 2014, as well as overseeing the Hospital's Performance Improvement Department from 2013 to 2016.

psychotropic medication was categorized according to its drug class, as defined in the PMMP.[11.]

The prevalence of youth in custody who are prescribed psychotropic medications remains high. Between September 1 and December 31, 2023, 32 percent of youth who were detained at the YSC were prescribed one or more psychotropic medications.[12] During that period, 171 youth were detained at YSC for at least 14 days. Among this cohort, 72 of the 171 youth, or 42 percent, were prescribed one or more psychotropic medications. At New Beginnings, 72 percent of youth who were housed at the facility between September 1 and December 31, 2023 were prescribed one or more psychotropic medications.

As noted above, there were 72 youth between September 2023 and December 31, 2023 housed at the YSC for more than 14 days who were prescribed psychotropic medications. Twelve of these youth, 17 percent, were selected for the sample.[13] Of the 12 youth at the YSC, 11 were prescribed more than two psychotropic medications. Thirteen unique medications prescribed from eight different drug classes for these 12 youth were reviewed.[14] Because a significant number of youth in the YSC sample were prescribed multiple psychotropic medications and because DYRS has developed different standards governing each medication class, OIJJFO elected to review two medications from different classes for four of the youth in

[11] For this review, OIJJFO utilized the same PMMP drug classes that had been verified by Michael Cohen M.D. as part of the 2022 review. *See* Report 2023-1 at 10.

[12] This percentage includes all youth who were admitted, and includes youth who did not have medications ordered for them, such as overnighters.

[13] The original sample included 16 youth, however four were removed from the sample. In one case, parental consent was not obtained and thus the youth was not administered psychotropic medication during the review period. In a second case, the youth was prescribed the medication by a nurse practitioner for medical reasons, not psychiatric, and therefore was not included in the sample. In two additional cases, the youths were not on psychotropic medications during the review period. However, among the 12 youth in the YSC sample, two medications were reviewed for each of four youth in the sample, for a total of 16 medications reviewed.

[14] For the YSC sample, the drug classes for the medications reviewed included atypical anti-psychotics (three youth), other anti-depressants (three youth), mood stabilizer-anti-convulsants (one youth), selective serotonin reuptake inhibitors (SSRI) (four youth), selective norepinephrine reuptake inhibitor (NPRI) (one youth), alpha agonist (two youth), stimulants (one youth) and anti-anxiety (one youth). There were no youth at YSC prescribed medications from the typical anti-psychotic or mood stabilizer (lithium) medication classes during this sampled period.

the YSC sample.[15]

At New Beginnings, 51 youth during the same period were prescribed one or more psychotropic medications.[16] A sample of 13 youth, 25 percent of those prescribed a psychotropic medication, was selected.[17] In the New Beginnings sample, 11 of the 13 youth in the sample were prescribed more than one psychotropic medication and OIJJFO reviewed two medications of different classes prescribed for three of the 11 youth. Overall, 12 unique medications for these 13 youth prescribed from six drug classes were reviewed.[18] The sample selection for both facilities was based upon length of stay and was designed to have as many drug classes as possible reviewed.

In its comments on the draft version of this report, DYRS states that "[t]he sampling methodology used for both study periods in the assessment is too small and may not be representative of the population being studied."[19] As noted above, at the YSC, the sample

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[15] In its comments on the draft of this report, DYRS states, "[t]he report states that 12 of [the youth] (or 17%) were 'selected' for analysis with selection rationale provided. Of these 12, 4 were then selected for further analysis." *See* Attachment 1 at 2. This is inaccurate. The records of all 12 youth were selected for analysis and analyzed. Four represents a subset of the sample and reflects youth for whom two prescribed psychotropic mediations were reviewed.

[16] In its comments on the draft report, DYRS states that "the report states that 51 youth were found to have used 1 or more psychotropic medications within the last 14 days." *See* Attachment 1 at 1. This is not accurate. There were 51 youth who were prescribed one or more psychotropic medications during the review period. The reference to 14 days reflects that in identifying the YSC sample, OIJJFO focused on youth who had lengths of stay of 14 days or longer, a time period which allows for the required baseline testing to have been completed before the ordering of psychotropic medication.

[17] Among the 13 youth at New Beginnings in the sample, two medications were reviewed for each of three youth who were on multiple psychotropic medications, totaling 16 medications reviewed. In its comments on the draft version of this report, DYRS states that "of these 13, 11 were then selected for final analysis." *See* Attachment 1 at 1. This is not accurate. As the report states, the records of 13 youth were reviewed. Eleven represents the number of the youth in the sample who were prescribed more than one psychotropic medication. Of these 11, one medication for eight of the 11 was reviewed, and two medications for the remaining three youth were also reviewed. The one psychotropic medication ordered for the remaining two youth (prescribed only one psychotropic medication) was also reviewed.

[18] For the New Beginnings sample, the drug classes for the medications reviewed included atypical anti-psychotics (three youth), other anti-depressants (three youth), mood stabilizer/anti-convulsants (two youth), selective serotonin reuptake inhibitors (SSRI) (two youth), alpha agonist (two youth), and stimulants (four youth). There were no youth prescribed medications from the typical anti-psychotic, norepinephrine reuptake inhibitor (NPRI), or mood stabilizer (lithium) medication classes during this review period.

[19] *See* Attachment 1 at 1.

included 17 percent of youth at the facility for 14 days or more and who were prescribed psychotropic medications, and New Beginnings the sample included 25 percent (*i.e.,* one out of every four) of youth who were prescribed psychotropic medications during the sample period. Both the sampling universes *and* the sample sizes were relatively small. While there are limitations in *precision* of calculations based on the sample (*i.e.,* calculations would result in larger, less precise margins of error), nevertheless, the samples, which were selected based on length of stay and to maximize the number of drug classes reviewed and without advance knowledge of medication monitoring practices in any of the cases, can provide valuable insight into consistency and trends in practice. This is one of the core functions of a quality assurance / continuous quality improvement program.

In comments on the draft report, DYRS also raises concerns regarding comparisons between the current analysis covering a 4-month period and the prior analysis, which covered a 9-month period starting in a different month. The comments note that "the follow-up represents a greater than two-fold difference in the duration of the respective study periods….[and] [t]herefore, there is a risk that the data gathered is not analogous because an entire 6-month period is omitted from the 2024 follow up analysis."[20] The comments raise concern about comparing the incidence of psychotropic use as well as validity of comparisons due to potential seasonality in disease or prescription trends. With respect to incidence comparisons, while it is true that the current assessment includes a sample from a shorter period, the analysis also controls for population over that shorter period by analyzing prescriptions among the population housed at the facilities over the shorter time period. It is also true that the assessment cannot draw any conclusions about causes of any differences in prescription incidence including

[20] *See* Attachment 1 at 2.

seasonality related to prescription practices and/or lab and clinical monitoring of psychotropic medications prescribed at the YSC and New Beginnings; however, the assessment was not designed to, nor does it make findings with respect to changes in the incidence of psychotropic prescriptions. In fact, the assessment does not address appropriateness of prescriptions at all. Rather, its focus is strictly on implementation of DYRS's policies governing administration and monitoring of youth prescribed psychotropic medications.

For each youth in the sample, the electronic health record (EHR) was reviewed by OIJJFO staff to confirm the selected psychotropic medications were prescribed, the dosage that was prescribed (including any dose changes) and administered, and the period over which the medications were prescribed and administered. To determine if tests or assessments required by the PMMP were ordered and administered, OIJJFO staff reviewed the following sections of the EHR: medical intake file; overnight medical screening; 7-day medical follow up; annual physical; lab reports; observation flow sheets; initial and follow up psychiatric notes; sick call notes; and the AIMS and EKG records. A data collection template reflecting the policy and PMMP requirements for the baseline and ongoing monitoring for each drug class reviewed was used for each medication reviewed. For consistency and comparative purposes, the data templates were the same as were used to conduct the 2019 and 2022 reviews of psychotropic medication monitoring.

III. Overview of Use of Psychotropic Medication at DYRS Facilities

A broad range of psychotropic medications are prescribed to youth in DYRS facilities. Below is a table summarizing all prescriptions for psychotropic medications for youth at the YSC during the four-month period between September 1 and December 31, 2023:

Table 1

Prescriptions at the YSC, by Psychotropic Drug Class September 1 - December 31, 2023		
Prescription by Psychotropic Drug Class	**Number of Prescriptions**	**Percentage of Psychotropic Prescriptions**
Sleep	238[21]	38.8%
Other Antidepressant	78	12.7%
Alpha Agonist	78	12.7%
Atypical Antipsychotic	67	10.9%
SSRI	66	10.7%
Stimulant	65	10.6%
Anticonvulsant	14	2.3%
Norepinephrine Reuptake Inhibitor	6	1.0%
Antianxiety Sleep	2	0.3%
Grand Total	**614**	**100%**

Similarly, the table below presents all prescriptions for psychotropic medications for youth housed at New Beginnings over the same four-month period:

Table 2

Prescriptions at New Beginnings, by Psychotropic Drug Class September 1 - December 31, 2023		
Prescription by Psychotropic Drug Class	**Number of Prescriptions**	**Percentage of Psychotropic Prescriptions**
Sleep	141[22]	27.4%
Stimulant	127	24.7%
Alpha Agonist	66	12.8%
SSRI	52	10.1%
Other Antidepressant	50	9.7%
Atypical Antipsychotic	43	8.3%
Anticonvulsant	36	7.0%
Grand Total	**515**	**100%**

[21] This total includes 222 prescriptions for Melatonin. This total also includes six prescriptions for Benadryl (diphenhydramine), which is an antihistamine sometimes used to relieve cold or flu symptoms. Because of the side effect of sleepiness, it is sometimes used for sleep as well. However, as was the case with prior studies, none of the prescriptions for these medications were included in the current review.

[22] This total includes 113 prescriptions for Melatonin and three prescriptions for Benadryl.

In its comments on the draft report, DYRS states the following:

> The follow up assessment states that use of psychotropic medications at NBYDC has increased. However, this data is at risk of being inflated because of the inclusion of non-psychotropic drugs in the dataset as the dependent variable. Psychotropics are mind- and mood-altering medications offered by clinicians to skillfully manage psychiatric disorders on behalf of a suffering patient. Including over-the-counter sleep agents like Benadryl and Melatonin as "psychotropics" is not universally (or even typically) supported by specialists, researchers, and practitioners in psychiatry.
>
> In the follow up analyses, the authors rely heavily on grouping these common grocery store sleep aids with more serious prescription medications such as the first-generation antipsychotics upon which to draw their conclusions. In fact, a clear majority of institutional psychotropics referred to in the analysis are in fact sleep aids with excellent risk-benefit ratios.[23]

Regardless of whether including Melatonin and Benadryl as psychotropics is universally or typically supported by specialists, researchers, and practitioners in psychiatry, the two medications are explicitly included by DYRS in its PMMP.[24] If DYRS believes these two medications should not be included in the PMMP, it should revise the policy to exclude them.[25] Furthermore, the tables presented intentionally disaggregate medications by drug class to make clear the relative prevalence of each class.[26] Notwithstanding their inclusion in the PMMP, OIJJFO intentionally did not include any over-the-counter sleep medications in the samples that were analyzed in this or prior reports.

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[23] *See* Attachment 1 at 2.

[24] PMMP July 2018 at pages 7 and 17. The PMMP notes Benadryl's potential complications or side effects, including the need to "[a]void use with other anticholinergic agents (TCA's, low potency antipsychotics)" as well as MAOIs. PMMP July 2018 at page 7. Additionally, with respect to Melatonin, the PMMP indicates that a contraindication is "other sedating agents poorly controlled seizures." PMMP July 2018 at page 17.

[25] OIJJFO recommended that DYRS update its PMMP and Medication Management Policy in their February 2023 Report. Report 2023-1 at pages 53-54. In its comments on the draft version of that report, DYRS agreed and indicated that they would implement the recommendation. Neither the PMMP nor Medication Management Policy have been updated as of the issuance of this report.

[26] The draft report was clear about how many prescriptions at each facility were for Benadryl. For clarity, the number of prescriptions for Melatonin have also been added to this final report. *See* notes 21 and 22, above.

IV. Standards for Use of Psychotropic Medication

DYRS adopted a Medication Management Policy, which includes specific provisions regarding the use of psychotropic medications at DYRS.[27] The policy states that psychotropic medication "shall be used solely for the purposes of providing effective treatment and protecting the safety of the youth and shall not be used as punishment or for the convenience of staff."[28] The policy also specifies that prior to initiating psychotropic medication, all youth shall have a medical assessment that includes a "Complete Blood Count ('CBC') with differential, platelets, hepatic, thyroid studies, chemistry panels, lipids, and a pregnancy test. Exceptions may be made by the prescribing advanced level provider if it is decided that, based on their documented clinical judgment, the youth should receive the medication concurrent with medical or other laboratory tests."[29] Continuing, the policy also requires that the prescribing practitioner "must order requisite testing and lab work to monitor for serious side effects that may occur with psychotropic drugs."[30] The potential side effects that the policy specifies the practitioner to monitor for and document include but are not limited to:

- Allergic reaction;
- Change in level of alertness;
- Eating problems;
- Change in heartbeat;
- Change in blood pressure;
- Fainting or dizziness;
- Abnormal posture, body or muscle movements or gait;
- Yellowing of eyes or skin; or
- Unusual bruising or bleeding.[31]

The policy mandates that medical and direct care staff document any observations of

[27] *See* Medication Management Policy at Section VI.G. The 2018 version of the Medication Management Policy was also used in the 2019 and 2022 reviews.
[28] *Id.* at Section II.
[29] *Id.* at Section VI.G.1.
[30] *Id.* at Section VI.G.2.
[31] *Id.*

possible side effects to psychotropic medications and report such to the prescribing practitioner, and the administering qualified health care professional (QHCP) is required to observe for and inquire of the youth about side effects on a daily basis.[32] The policy also requires formal monitoring for tardive dyskinesia twice yearly, including an AIMS test or other process/format of the onsite advanced level provider's choice, which shall be documented in the EHR.[33]

In addition, in July 2018, the DYRS published its PMMP, which sets forth clinical standards, by drug class, for use of psychotropic medications for youth, as well as requirements for a medical work-up before psychotropic medications are prescribed and for medical follow-up once they are prescribed.[34] The PMMP tailors the specific information to each of 18 drug classes and provides clear guidance to prescribing health care practitioners regarding their use, risk, and monitoring of health effects. While there are differences within the standards among the 18 drug classes, each class requires some type of medical work-up before psychotropic medication is prescribed and some type of medical follow-up to monitor the health of youth who are taking such medications. The policy and PMMP complement each other and provide a comprehensive approach to ordering and monitoring the use of psychotropic medication at the DYRS facilities.

Utilizing the same criteria that was utilized by the Special Arbiter in her 2019 review,[35]

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[32] *Id.* at Sections VI.G.3.a. and VI.G.4.

[33] *Id.* at Section VI.G.5.a.

[34] PMMP July 2018 at page 1. The PMMP has not been updated since its adoption in July 2018 and the version used in this review was also used in both the 2019 and 2022 reviews. The PMMP is organized by drug class, and each drug class includes class-specific information relating to indications for use, dose and appropriate frequency for dose changes, possible interactions with other medications or effects of medication use, complications and side effects, cautions and contraindications as well as specific medical work-up and monitoring follow-up requirements.

[35] Report 2023-1 at 38. In 2019, the Special Arbiter in the *Jerry M. v. District of Columbia*, Case No. 1519-85, Superior Court of the District of Columbia also issued a report that included an assessment of DYRS' fidelity to the Medication Management Policy and PMMP requirements around use of psychotropic medications. In the report, the Special Arbiter found that the that DYRS had not yet implemented appropriate monitoring of youth prescribed psychotropic medications. The Special Arbiter's Report to the Court Regarding Defendants' Progress Toward Meeting Work Plan Requirements Related to Medical and Dental Services at the Youth Services Center and the New Beginnings Youth Development Center, filed December 20, 2019 (December 2019 Report) at pages 27-32. As reported by the Special Arbiter, at the time of the review, only just over 50 percent of youth at the YSC had all required

the OIJJFO conducted a review of prescribing practices against the Medication Management Policy and the PMMP in late 2022 and published its findings in a February 2023 Report.[36] At that time, OIJJFO found that of the 15 youth in the 2022 YSC sample, seven youth, 47 percent, received *all baseline* labs and assessments specified in the Medication Management Policy and the PMMP for their prescribed medication prior to the initiation of the medication, and eight, 53 percent, did not received all required assessments and labs.[37] With respect to the *ongoing* monitoring of psychotropic medication prescribed to YSC youth, nine of 15 youth, 60 percent, received all of the labs and assessments required by the PMMP and policy for their specific medication at the specified intervals, and six youth, 40 percent, were missing one or more of the follow-up labs or assessments.[38] Of the 15 youth in the New Beginnings sample, six youth, 40 percent, received *all baseline* tests and labs specified in the Medication Management Policy and the PMMP for their prescribed medication prior to the initiation of the medication, and nine youth, 60 percent, did not received all the required assessments or labs.[39] For New Beginnings youth, the 2022 review found that 73 percent of youth received all the labs and assessments required by the Policy and PMMP for ongoing monitoring of youth prescribed psychotropic

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baseline labs and assessments, and none of the youth at YSC had all the required labs and assessments required for monitoring the use of psychotropic medications. *Id.* at 29-30. She found that for youth at New Beginnings, 72 percent of youth had all the required baseline labs and assessments before the initiation of psychotropic medications and 50 percent had all the required labs and assessments for continued use of the medications. *Id.* at 30. Therefore, given that DYRS was not meeting the requirements of the Jerry M. Work Plan, under the terms of the Order dismissing the Jerry M. case, management of youth prescribed psychotropic medications became subject to further monitoring by OIJJFO.

[36] Report 2023-1 at 37-48. In conducting that review, OIJJFO utilized the same criteria that was utilized by the Office of the Special Arbiter in the 2019 review concerning the timeliness of tests and examinations; a test completed within twelve months prior to starting psychotropic medication was considered to be current for purposes of the initial medical work- up. For follow-up tests due at six month or annual intervals, tests completed within two months before or after the follow-up labs were due were considered timely and for tests required at two- month intervals, tests within one month of the due date were considered timely. Labs or tests due monthly were considered timely if they were administered within one week of the due date. These same standards have been applied in the current review.

[37] Report 2023-1 at 38.

[38] *Id.* at 41.

[39] *Id.* at 45.

medications, and 27 percent of youth did not.[40] Because of the risks associated with use of psychotropic medications for youth, and given the results of the 2022 review, the OIJJFO determined it was appropriate to conduct a reassessment of DYRS' performance in implementing its Medication Management Policy and PMMP at this time.

V. Findings

A. Youth Services Center

OIJJFO reviewed the records relating to the prescriptions of 13 different medications from eight unique drug classes prescribed to 12 youth during the period of September through December 2023, to determine if the requirements of the Medication Management Policy and PMMP related to medical work-up and medical monitoring of youth on psychotropic medications were implemented. As noted above, the 12 youth included four youth who were prescribed medications from different drug classes and for whom OIJJFO staff reviewed medications from two different classes, bringing the total to 16 medications reviewed. In conducting this review, OIJJFO utilized the same criterion used in the 2022 review by the OIJJFO and by the Office of the Special Arbiter in the 2019 review concerning the timeliness of tests and examinations; a test completed within twelve months *prior* to starting psychotropic medication was considered to be current for purposes of the initial medical work- up.[41] For follow-up tests due at six month or annual intervals, tests completed within two months before or after the follow-up labs were due were considered timely and for tests required at two-month intervals, tests within one month of the due date were considered timely.[42] Labs or tests due

[40] *Id.* at 46.
[41] *Id.* at 38.
[42] *Id.*

monthly were considered timely if they were administered within one week of the due date.[43]

In its comments on the draft report, DYRS state:

> [W]e should note that while the assignment of the stimulants (like ADHD medications) as psychotropics is typical the risk profile of these commonly used agents differs significantly from the more concerning benzodiazepines, antipsychotics, and even the antidepressants. Use of the common stimulants is not associated with respiratory depression, metabolic syndrome, or tardive dyskinesia, and does not typically require laboratory testing - all possible adverse effects for which this report was written.
>
> If stimulant medications and sleep agents were rightly removed from this analysis, the use of psychotropic medication use at NBYDC would fall to a more accurate 48 percent which is considerably lower than the national average.[44]

OIJJFO analyzed psychotropic medication management as prescribed by DYRS's PMMP. Each drug class in the PMMP has its own monitoring guidelines, established by DYRS in accordance with the potential adverse effects of the different drug classes. As previously stated, if the agency believes the monitoring parameters for any drug classes should be revised, it should do so.[45]

1. Baseline Tests and Assessments

For the 16 medications prescribed for youth in the YSC sample, seven medications (44 percent) involving four youth were prescribed after the youth received all baseline labs and assessments specified in the Medication Management Policy and the PMMP for their prescribed medication; and nine medications (56 percent) involving eight youth, were not. Three medications involving three youth were prescribed and administered even though one test or assessment was missing. Six medications involving five youth were prescribed and administered despite the absence of more than one baseline test or assessment.

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[43] *Id.*
[44] *See* Attachment 1 at 2-3.
[45] *See* note 25.

Of the eight youth who did not receive all the required baseline labs and assessments, three youth were missing one lab or assessment, two youth were missing two of the required labs or assessments and two youth were missing three of the required labs or assessments. One youth was missing five of the required labs or assessments, including liver function tests, chemistry, thyroid and lipid panels and a baseline AIMS test.[46]

All but one of the youth in the sample had a current physical examination at the time the psychotropic medication was ordered, and both youth for which the record identified positive cardiac risk factors (by family history) received EKGs.[47] Baseline vital signs, height, weight and body mass index (BMI) were obtained for all youth in the sample for all medications ordered. However, no pregnancy tests were found for any of the female youth in the sample.

Table 3, below, sets forth the specific lab work or assessment required and the number of cases in which the lab work or assessment was administered consistent with the policy or PMMP. Below is a summary of findings by required test or assessment.

[46] The Medication Management Policy requires AIMS testing for all psychotropic medications; however, the PMMP, which is more specifically tailored to individual psychotropic drug classes, requires AIMS testing for certain classes of drugs. *See* note 58. For this analysis, OIJJFO staff relied on the PMMP requirements. In the 2019 review, Dr. Cohen noted that the AIMS test referenced in the Medication Management Policy and the PMMP is a structured assessment for involuntary movements, and that references to the absence of side effects in clinical notes were not substitutes for AIMS testing at the intervals specified in the policy or the PMMP for those medications for which the policy or PMMP specifically mandate AIMS testing. December 2019 Report, Ex. 1 at 33. This principle was applied in this review, consistent with prior reviews. Of the youth in the 2023 YSC sample under review, two additional youth were prescribed medications for which AIMS testing was required by the PMMP; and only one of these youth had a baseline AIMS test completed at the time the medication was prescribed.

[47] The PMMP requires an EKG if there is a family history of cardiac problems or if the youth is positive for cardiac risk factors for some drug classes. In most records, the medical intake note would simply state negative (or include similar language) in the family history section; however, some records had no recorded cardiac history. For the purpose of this review, in these cases it was assumed there was no family history. In none of the cases in which the doctor ordered one of the designated drug classes requiring an EKG in certain instances did the psychiatric note explicitly address either the presence or absence of risk factors that would require an EKG.

Table 3

Summary of Findings Baseline Tests and Labs for Psychotropic Medications Prescribed at the YSC[48]			
Lab or Assessment	**Number Meeting Requirement**	**Number Not Meeting Requirement**	**Number Not Applicable/ Not Required**
CBC with white cell differential and platelets[49]	16	0	0
Liver function tests[50]	15	1	0
Chem panel (including glucose, BUN and creatine)[51]	15	1	0
Thyroid[52]	10	6	0
Lipids[53]	13	3	0
Urinalysis[54]	16	0	0
Pregnancy[55]	0	4	12
Vital signs	16	0	0
Height, weight, BMI	16	0	0
Special - EKG[56]	2	0	14
Physical Exam[57]	15	1	0

[48] A prescribed medication reflected in Tables 3 to 6 is considered to meet the requirement if the testing or assessment occurred at the intervals and frequency specified in the PMMP and policy. A requirement is considered to be not applicable or not required if the policy or PMMP did not require it for the particular medication reviewed or if the youth was no longer in custody or on the medication at the time a particular lab or assessment was due. This Table reflects the number of medications reviewed, not the number of youth, since some tests or assessments are not applicable to all medications.

[49] This is required for all psychotropic medications by the Medication Management Policy. In addition, the PMMP requires this lab for the following drug classes: First generation antipsychotics, second generation anti-psychotics, mood stabilizer - lithium, and mood stabilizer - anticonvulsants.

[50] This is required for all psychotropic medications by the Medication Management Policy. In addition, the PMMP requires this lab for the following drug classes: first generation antipsychotics, second generation anti-psychotics, psychostimulants and selective norepinephrine reuptake inhibitors (Strattera), tricyclic antidepressants, and mood stabilizer - lithium.

[51] This is required for all psychotropic medications by the Medication Management Policy. In addition, the PMMP requires this lab for the following drug classes: first generation antipsychotics, second generation anti-psychotics, mood stabilizer - lithium, and mood stabilizer - anticonvulsants.

[52] This is required for all psychotropic medications by the Medication Management Policy. In addition, the PMMP requires this lab for the following drug class: mood stabilizer lithium.

[53] This is required for all psychotropic medications by the Medication Management Policy. In addition, the PMMP requires this lab for the following drug classes: First generation antipsychotics, second generation anti-psychotics.

[54] This is required for all psychotropic medications by the Medication Management Policy. In addition, the PMMP requires this lab for the following drug classes: first generation antipsychotics, tricyclic antidepressants, mood stabilizer - lithium, mood stabilizer - anticonvulsants.

[55] This is required for all psychotropic medications by the Medication Management Policy. In addition, the PMMP requires this lab for the drug class: other anti-depressants (venlafaxine).

[56] This is applicable to the following drug classes: second generation anti-psychotics (for Geodon), psychostimulants and selective norepinephrine reuptake inhibitors (Strattera), (if positive cardiac risk factors), alpha-adrenergic agonists (if positive cardiac risk factors), tricyclic antidepressants, mood stabilizer - lithium if multiple medications, relevant history and medical conditions, mood stabilizer (Tegretol).

[57] This is applicable to all drug classes in the PMMP except for anti-Parkinson/anticholinergics and other anti-depressants.

Special - Abnormal movements/AIMS test[58]	1	2	13
Special - order establishing BP and/or pulse parameters	0	2	14
Special - serum drug levels[59]	1	0	15

2. Tests and Assessments Required as Part of Ongoing Monitoring

With respect to the ongoing monitoring of psychotropic medication prescribed to the 12 YSC youth, three youth (including one youth who was prescribed medications from two drug classes) received all of the labs and assessments required by the PMMP and policy for the reviewed medication(s) at the specified intervals.[60] Three (of four) youth for whom two psychotropic medications were reviewed received the required ongoing monitoring tests and assessments for one but not both medications reviewed.[61] Three youth for whom only one psychotropic medication was reviewed were missing one of the follow-up labs or assessments required by PMMP and policy.[62] Finally three youth were missing more than one of the PMMP or policy required follow up tests and assessments for their prescribed medication.[63] Table 4 below sets forth the specific required monitoring interventions and the status of compliance for each of the 16 medications reviewed.

[58] This is required by the Medication Management Policy. In addition, the PMMP requires AIMS testing for the following drug classes: first and second-generation antipsychotics and long-acting anti-psychotic injectables.
[59] This is applicable to the following drug classes: mood stabilizer - lithium, and mood stabilizer - anticonvulsants.
[60] Youth include AH, TA, and CB (both 1 and 2). This is somewhat lower than in 2022 when 60 percent of youth had all the required labs and assessments required by policy and the PMMP.
[61] MH, KP, and TJ. As noted, the YSC sample included four youth who were prescribed, and for whom OIJJFO reviewed, more than one medication from different medication classes. Among these three youth, one youth (CB1 and CB2) received all required ongoing monitoring tests and assessments for both medications, one youth (MH1) received the required ongoing monitoring tests and assessments for one but not both medications.
[62] These youth are KH, LC, and IB.
[63] The three include JP, RM, and KR.

Table 4

Summary of Findings Medical Follow Up for Prescribed Psychotropic Medications at the YSC			
Lab or Assessment[64]	**Number Meeting Requirement**	**Number Not Meeting Requirement**	**Number Not Applicable/ Not Required**
CBC with white cell differential and platelets[65]	3	0	13
Liver function tests[66]	3	0	13
Chem panel (including glucose, BUN and creatine)[67]	2	0	14
Thyroid[68]	0	1	15
Lipids[69]	1	0	15
Urinalysis[70]	1	1	14
Pregnancy	n/a	n/a	16
Vital signs[71]	4	1	11
Height, weight, BMI[72]	3	3	10
EKG[73]	0	0	16
Physical Exam[74]	0	1	15

[64] The Medication Management Policy provides that the prescribing practitioner "must order requisite testing and lab work to monitor for serious side effects that may occur with psychotropic drugs" but does not specify particular lab work or testing. Medication Management Policy, Section G. 2. Among the issues for which the practitioner must monitor include allergic reaction, change in level of alertness, eating problems including weight loss or weight gain, changes in heartbeat, change in blood pressure, fainting or dizziness, abnormal posture, body or muscle movements or gait, yellowing of eyes or skin or unusual bruising or bleeding.

[65] The PMMP requires CBC diff/platelets at specific intervals for the following drug classes: first-and second-generation and long-acting injectable anti-psychotics, serotonergic anti-depressants, and mood stabilizer anti-convulsants.

[66] The PMMP requires LFTs at specific intervals for the following drug classes: first-and second-generation and long-acting injectable anti-psychotics, psychostimulants and selective norepinephrine reuptake inhibitors (Strattera), mood stabilizers -anti-convulsants, and serotonergic anti-depressants.

[67] The PMMP requires a chemistry panel at specific intervals for the following drug classes: first-and second-generation and long-acting injectable anti-psychotics, and serotonergic anti- depressants.

[68] The PMMP requires thyroid function tests at specific intervals for the following drug classes: mood stabilizer, lithium.

[69] The PMMP requires a blood lipid panel at specific intervals for the following classes of drugs: second-generation anti-psychotics and long-acting anti-psychotic injections, psychostimulants and selective norepinephrine reuptake inhibitors.

[70] The PMMP requires urinalyses at specific intervals for the following classes of drugs: first- and second-generation antipsychotics, long-acting injectable anti-psychotics, serotonergic anti-depressants, and mood stabilizer-lithium.

[71] The PMMP requires some or all vital signs at specific intervals for the following drug classes: first-generation, second-generation and long-acting injectable anti-psychotics, psychostimulants and selective norepinephrine reuptake inhibitors (Strattera), alpha-adrenergic agonists, tricyclic antidepressants, serotonergic anti-depressants, and other anti-depressants.

[72] The PMMP requires the measurement of height, weight and body mass index (BMI) at specific intervals for the following classes of drugs: first and second generation antipsychotics, long acting injectable anti-psychotics, psychostimulants, selective norepinephrine reuptake inhibitors, serotonergic anti-depressants, mood stabilizer-lithium, and mood stabilizer -anti-convulsants.

[73] The PMMP requires an EKG at specific intervals and under specific conditions for the following classes of drugs: first and second-generation antipsychotics, alpha-adrenergic agonists, tricyclic antidepressants, and mood stabilizer – lithium.

Abnormal movements/AIMS test[75]	0	3	13
Special - BP and/or pulse parameters	0	2	14
Special - serum drug levels[76]	0	1	15

Some trends identified in the 2022 review continued in this review. AIMS tests required by the PMMP were not completed as specified in the PMMP; of the three youth in the sample prescribed medication for which an AIMS test is required, none had AIMS tests completed at the mandated intervals. While the psychiatric notes typically included a notation that the youth reported no side effects or that none were observed, under the PMMP that does not suffice for an AIMS test.[77] Monitoring of weights and BMI also were not completed in almost half of the required instances, but in none of those cases was there significant weight gain evidenced when weights were obtained. Finally, none of the cases in which the blood pressure and/or pulse parameters for holding doses should have been included in the prescribing orders included such parameters.

[74] The PMMP requires a physical exam after the start of psychotropic medication at specific intervals for the following classes of drugs: first and second-generation anti-psychotics, long-acting psychotic injections, psychostimulants, selective norepinephrine reuptake inhibitors, alpha-adrenergic agonists, tricyclic anti-depressants, serotonergic anti-depressants and mood stabilizers-lithium.

[75] For youth on first or second-generation antipsychotics or long-acting injectables, the PMMP requires monitoring for abnormal movements each month and AIMS testing every six months.

[76] The PMMP requires periodic serum levels at defined intervals for specific medications within the following classes of medications: first generation antipsychotics, long acting anti-psychotic injectables, mood stabilizer-lithium, mood stabilizer -anti-convulsants. For youth prescribed psychotropic medication, the Medication Management Policy requires at least bi-annual screening for TD by the QHCP on either the AIMS form or a process/format of the practitioner's choice.

[77] *See* note 58.

B. New Beginnings

OIJJFO staff reviewed the records of 13 youth prescribed psychotropic medications at New Beginnings[78] during the period of September 2023 to December 2023 to determine if the requirements of the Medication Management Policy and PMMP related to medical workup and medical monitoring of youth on psychotropic medications were implemented. The sample included a review of 12 different medications from six unique drug classes.[79] Several youth in the sample were prescribed more than one psychotropic medication, and OIJJFO staff reviewed two medications for three of the youth prescribed more than one psychotropic medication. Thus, among the 13 youth in the sample, a total of 16 prescriptions for psychotropic medications were reviewed. The same standards for timeliness described above were utilized to review this sample, and the same data collection templates also were used.

1. Baseline Tests and Assessments

Of the 13 youth in the New Beginnings sample, three youth (23 percent) received all baseline tests and labs specified in the Medication Management Policy and the PMMP prior to the initiation of the medication.[80] Ten other youth (77 percent) did not receive all required baseline assessments or labs for the respective class of the prescribed medication. Specifically, none of the three youth in the sample for whom two medications were reviewed received all required tests or assessments for both medications; one received all of the baseline tests and assessments relevant to one of the medications but was missing one test or assessment relating to

[78] Three of the youth in the sample were prescribed two medications from different classes, and both medications were reviewed since the baseline and ongoing standards for prescribing differ.

[79] The medications reviewed included Trileptal, Minipress (Prazosin), Seroquel (Quetiapine ER), Vyvanse, Clonidine, Trazodone, Prozac, Abilify, Amphetamine (Adderall), Zoloft, Focalin and Depakote. The drug classes included mood stabilizers-anticonvulsants, other anti-depressants, stimulants, alpha agonist, SSRI, and atypical antipsychotics.

[80] JH, MB, and JE. In 2022, six of 15 youth, or 40 percent, had all the required baseline tests and assessments.

the second medication,[81] one was missing one baseline test or assessment related to one medication and more than one baseline test or assessment related to the second medication,[82] and one was missing more than one test or assessment for both medications.[83] Of the remaining seven youth, two were missing one lab or test for at least one medication, and five youth were missing two or more of the required labs or tests.

Of the 10 youth who did not receive all the required assessments or labs for the respective class of the prescribed medication, two youth were missing four required labs or assessments (liver function, blood chemistry, thyroid, and lipids)[84] and one youth was missing five of the required labs or tests, including the liver function, blood chemistry, thyroid, lipid panel and the establishment of blood pressure parameters.[85] Additionally, three youth in the sample were prescribed medications for which AIMS testing to establish a baseline was required; only one youth had a baseline AIMS test completed at the time the medication was prescribed.[86] All youth in the sample had a current physical examination at the time the psychotropic medication was ordered, and both youth for which the record identified positive cardiac risk factors (by family history) received an EKG.[87]

Table 5 below sets forth the specific lab work or assessment required and the number of cases in which the lab work or assessment was administered consistent with the policy or PMMP.

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[81] KD.
[82] RW.
[83] JOH.
[84] RMG and EP.
[85] JOH1.
[86] This finding is consistent with the findings in 2022 where only one of three youth had a baseline AIMS test completed. One youth in the current sample began atypical anti-psychotic medication in February 2023, which was discontinued in August 2023 for one week then restarted later that same month. He was given an AIMS test, but not until September 2023, almost a month after restarting the medication.
[87] In the 2022 review, only two of four youth who should have had an EKG before the initiation of psychotropic medication received the test.

Table 5

Summary of Findings Baseline Workup for Prescribing Psychotropic Medications at New Beginnings[88]			
Lab or Assessment	**Number Meeting Requirement**	**Number Not Meeting Requirement**	**Number Not Applicable / Not Required**
CBC with white cell differential and platelets	16	0	0
Liver function tests	13	3	0
Chem panel (including glucose, BUN and creatine)	13	3	0
Thyroid	6	10	0
Lipids	9	7	0
Urinalysis	16	0	0
Pregnancy	n/a	n/a	16
Vital signs	16	0	0
Height, weight, BMI	16	0	0
EKG[89]	2	0	14
Physical Exam	16	0	0
Abnormal movements/AIMS test	1	2	13
Special - BP and/or pulse parameters	0	2	14
Special - serum drug levels	0	0	16

2. Tests and Assessments Required as Part of Ongoing Monitoring

With respect to the ongoing monitoring of youth on psychotropic medication at New Beginnings, six individuals (taking six medications) received all the required follow up monitoring in accordance with the PMMP or policy and one individual who was taking two reviewed medications received the required follow up monitoring for one, but not both medications. With respect to the second medication prescribed to this youth, two follow up assessments (urinalysis and AIMS test) were missing.[90] One individual for whom two medications were reviewed was missing his chemistry panel, liver function tests, lipid panel,

[88] The numbers in this Table reflect medications reviewed, not number of youth. As noted previously, two medications for three youth in the sample were reviewed.
[89] The PMMP require baseline EKG testing for youth with cardiac risk factors when prescribing first or second-generation anti-psychotics, alpha-adrenergic agonists, tricyclic anti-depressants, and mood stabilizers-lithium. Three youth in the sample met the criteria for EKG testing.
[90] JOH2 and DB.

thyroid test, urinalysis and an updated physical examination.[91] CBC/platelets and liver function blood tests were missing for two other individuals,[92] and urinalyses were missing for two additional individuals.[93] One individual was missing the monthly height, weight and BMI checks for two non-consecutive months required for youth prescribed Adderall[94] and three youth were missing one or more AIMS tests.[95] All youth had vital signs taken as required by the PMMP or policy and the required monitoring for the one youth prescribed medication requiring monitoring of serum levels was completed as required by the policy and PMMP. As was the case with the YSC, blood pressure parameters to hold doses for those taking medications known to affect blood pressure were not present in any of the relevant cases.

See Table 6 below for a summary of monitoring at New Beginnings.

[91] RW1.
[92] JH and JL.
[93] DB and KD2.
[94] KD1.
[95] JOH2, DB, and RW1.

Table 6

Summary of Findings Medical Follow Up for Prescribing Psychotropic Medications at New Beginnings			
Labs/Assessments	**Number Meeting Requirement[96]**	**Number Not Meeting Requirement**	**Number Not Applicable / Not Required**
CBC with white cell differential and platelets	4	2	10
Liver function tests	3	3	10
Chem panel (including glucose, BUN and creatine)	3	1	12
Thyroid	2	1	13
Lipids	1	2	13
Urinalysis	0	4	12
Pregnancy	0	0	16
Vital signs	8	0	8
Height, weight, BMI	10	1	5
EKG	1	0	15
Physical Exam	0	2	15
Abnormal movements/AIMS test	0	3	13
Special - BP and/or pulse parameters	0	2	14
Special - serum levels	1	0	15

Regular assessment by the psychiatrist occurred for all youth in the sample. Appointments were scheduled weekly until the psychiatrist determined that the youth was stabilized, and then monthly follow up occurred.[97] The notes reflected that the psychiatrist obtained input from the youth and family in making treatment decisions and was responsive to concerns expressed by youth around medications. For all youth on atypical anti-psychotics, weights and BMI were monitored closely.[98] In one case, the blood pressure of a youth

[96] Cases are considered compliant it the monitoring occurred at the intervals and frequency specified in the PMMP and policy. If the monitoring was missed or late, it is considered to be non-compliant. Additionally, a test or assessment is considered not applicable or not required if the youth was not in custody or on the medication at the time designated in the PMMP or policy, or if the PMMP did not require the particular test or assessment.

[97] There were multiple instances in which a youth refused to see the psychiatrist, in which case a follow up was scheduled weekly until the youth agreed to be seen. In several cases, medications were discontinued for repeated refusals, which then promptly resulted in the youth agreeing to meet with the psychiatrist.

[98] In one case a youth's weight increased from 88.4 pounds upon admission in early November 2022 to 140.8 pounds by mid-January 2024. Based on his review of the medical record, Dr. Cohen observed that the youth was underweight upon admission and gained weight when provided extra portions of food and dietary supplements. The youth was followed by a nutritionist, who appropriately reduced his nutritional supplements as the youth gained weight. Dr. Cohen concluded that weight gain was an intentional treatment, not an unintentional side effect of psychiatric medications.

prescribed a medication known to cause low blood pressure was closely monitored and fluctuated from normal to borderline low (as low as 95/61) during the review period, but there was no order setting blood pressure parameters for nursing to hold the dose. As with the YSC, psychiatric notes regularly referenced the absence of side effects, but did not detail for what side effects the youth was assessed.[99] Notes for those on anti-psychotics did not specifically address the presence or absence of involuntary movements but no AIMS test was performed to fully assess the presence of involuntary movements.

C. Comparison of 2022 and 2024 Findings and Recommendations

Tables 7 and 8 below compare the findings relating to DYRS' compliance with the Medication Management Policy and the PMMP, by facility, for the most recent two reviews. Those highlighted in green reflect performance improved or was consistent between reviews, and those in red highlight declining performance or performance below 90 percent. Included in the Tables are the total number of medications reviewed for which the test or assessment is required by Policy or the PMMP.

[99] *See* page 18.

Table 7

Comparison of Findings, 2022 versus 2024: <u>Baseline</u> Medical Work-up, By Facility				
Test or Assessment	**Percent Compliant** (Number of Total Medications Applicable for 2024 Review)		**Percent Compliant** (Number of Total Medications Applicable for 2024 Review)	
	YSC 2022	**YSC 2024**	**NB 2022**	**NB 2024**
CBC with white cell differential and platelets	87	100 (16)	100	100 (16)
Liver function tests	93	94 (16)	94	81 (16)
Chem panel (including glucose, BUN and creatine)	93	94 (16)	94	81 (16)
Thyroid	87	63 (16)	71	38 (16)
Lipids	87	81 (16)	88	56 (16)
Urinalysis	93	100 (16)	100	100 (16)
Pregnancy	50	0 (4)	50	n/a (0)
Vital signs	100	100 (16)	100	100 (16)
Height, weight, BMI	93	100 (16)	100	100 (16)
Special - EKG	100	100 (2)	50	100 (2)
Physical Exam	93	94 (16)	94	100 (16)
Special - abnormal movements/AIMS test	25	33 (3)	100	33 (3)
Special - order establishing BP and/or pulse parameters	0	0 (2)	0	0 (2)
Special - serum levels	n/a	0 (1)	100	n/a (0)

Table 8

Comparison of Findings, 2022 versus 2024 Ongoing Monitoring of Psychotropic Medication, By Facility				
Test or Assessment	**Percent Compliant** (Number of Total Medications Applicable for 2024 Review)		**Percent Compliant** (Number of Total Medications Applicable for 2024 Review)	
	YSC 2022	**YSC 2024**	**NB 2022**	**NB 2024**
CBC with white cell differential and platelets	80	100 (3)	100	67 (6)
Liver function tests	80	100 (3)	33	50 (6)
Chem panel (including glucose, BUN and creatine)	75	100 (2)	33	75 (4)
Thyroid	0	0 (1)	0	67 (3)
Lipids	100	100 (1)	33	33 (3)
Urinalysis	33	67 (2)	66	0 (4)
Pregnancy	n/a	n/a	n/a	n/a
Vital signs	100	80 (5)	100	100 (8)
Height, weight, BMI	86	50 (6)	64	92 (11)
Special - EKG	n/a	n/a	n/a	100 (1)
Physical Exam	100	0 (1)	n/a	0 (2)
Special - abnormal movements/AIMs test	33	0 (3)	50	0 (3)
Special - order establishing BP and/or pulse parameters	0	0 (2)	0	0 (2)
Special - serum levels	100	100 (1)	n/a	100 (1)

Overall, there remain gaps in implementing these standards. As in prior reviews, blood tests relating to thyroid, lipids, and pregnancy continue to be missed, and completion of AIMS tests or documentation of specific observation relating to abnormal movements continues to be problematic. In the 2022 review, OIJJFO recommended a review of both the Medication Management Policy as well as updating the PMMP to ensure consistency and that each reflect the current standard of care. While it appears the Medication Management Policy may be under review, the PMMP likewise should be reviewed, as it is now six years old and standards may well have changed.

Additionally, OIJJFO reiterates its prior recommendations that DYRS explore the feasibility of creating several categories of orders in its Pharmacy module that include all

required labs relating to specific classes of medication and reflect baseline and ongoing monitoring PMMP and policy requirements. This would, in all likelihood, minimize the propensity, identified in this and previous reviews, for physicians to miss one or more labs or assessments that are required for a particular medication class.

Attachment 1

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF YOUTH REHABILITATION SERVICES
OFFICE OF THE DIRECTOR | 450 H STREET, NW, WASHINGTON D.C. 20001

July 10, 2024

Mark Jordan
Executive Director
Office of Internal Juvenile Justice Facility Oversight
200 Massachusetts Avenue, NW, Suite 700, Washington, DC 20001

Dear Director Jordan:

I am writing to provide comment regarding the confidential draft of the Office of Independent Juvenile Justice Facility Oversight's (OIJJFO) *Follow-up Assessment of Psychotropic Medication Management at the Youth Services Center (YSC) and New Beginnings Youth Development Center (NBYDC)* shared with the Department of Youth Rehabilitation Services (DYRS) on June 18, 2024.

I have reviewed the draft provided, including the assessment methodology, your articulation of the DYRS Medical Management Policy (MMP), findings and recommendations. My comments focus on the following three concerns:

1. The method used to determine the sample size is unclear and the small sample size may not be representative of the population.
2. The timeframes selected to conduct a comparative analysis are not the same and are therefore not analogous.
3. The dataset includes over-the-counter medications that are not psychotropic, therefore, the findings may be inflated.

DYRS prioritizes the development, review, implementation of and compliance with our Medication Management Policy (MMP), which governs the use of psychotropic medications as a part of a youth's treatment while in DYRS care. Thank you for providing the opportunity to comment.

The method used to determine the sample size is unclear and the small sample size may not be representative of the population.

The sampling methodology used for both study periods in the assessment is too small and may not be representative of the population being studied. In the follow-up period, the report states that 51 youth were found to have used 1 or more psychotropic medications within the last 14 days. The report then states that 13 of the youth (or 25%) were "selected" for analysis. Further, of these 13, 11 were then selected for final analysis. However, there is no explanation for why that sample size was selected nor what process was used to do so.

Similarly, at YSC, a total of 72 youth were found to have used 1 or more psychotropic medications within the last 14 days. The report states that 12 of them (or 17%) were "selected" for analysis with selection rationale provided. Of these 12, 4 were then selected for further analysis.

In addition, in both the NBYDC and YSC samples, this improper statistical methodology whittles down the sample size to very small numbers. Therefore, this small sample size does not bear any semblance to the characteristics of the actual population under investigation. This methodology does not adhere to the basic tenets of population sampling and randomization whereby proper inferences can be drawn from sampling data. Without such rigor, conclusions made by this type of methodology are highly subject to error.

The timeframes selected to conduct a comparative analysis are not the same and therefore are not analogous.

The report articulates that the assessment is intended to be a follow up to the analysis and findings from an earlier OIJJFO report from 2023 that covered similar medical matters over a 10-month period (10/1/21 to 6/30/22). However, the follow up assessment analyzes psychotropic medication use at NBYDC over a 4-month period (9/1/23 to 12/31/23) for direct comparison. The follow up analysis states that NBYDC saw an increase in psychotropic use from 66% to 72%. While the analytic methodology may have possibly been similar between these two periods, the follow up represents a greater than two-fold difference in the duration of the respective study periods. Therefore, there is a risk that the data gathered is not analogous because an entire 6-month period is omitted from the 2024 follow up analysis.

In addition, the follow up study period begins a month earlier in the year than the initial study. Doing so further risks distorting any veracity of the comparative method. What is at stake here is the importance of accounting for possible seasonality in either disease burden or prescribing trends when comparisons are drawn.

The dataset includes over-the-counter medications that are not psychotropic, therefore, the findings may be inflated.

The follow up assessment states that use of psychotropic medications at NBYDC has increased. However, this data is at risk of being inflated because of the inclusion of non-psychotropic drugs in the dataset as the dependent variable. Psychotropics are mind- and mood-altering medications offered by clinicians to skillfully manage psychiatric disorders on behalf of a suffering patient. Including over-the-counter sleep agents like Benadryl and Melatonin as "psychotropics" is not universally (or even typically) supported by specialists, researchers, and practitioners in psychiatry.

In the follow up analyses, the authors rely heavily on grouping these common grocery store sleep aids with more serious prescription medications such as the first-generation antipsychotics upon which to draw their conclusions. In fact, a clear majority of institutional psychotropics referred to in the analysis are in fact sleep aids with excellent risk-benefit ratios.

In addition, we should note that while the assignment of the stimulants (like ADHD medications) as psychotropics is typical the risk profile of these commonly used agents differs significantly from the more concerning benzodiazepines, antipsychotics, and even the antidepressants. Use of the common stimulants is not associated with respiratory depression, metabolic syndrome, or tardive

dyskinesia, and does not typically require laboratory testing - all possible adverse effects for which this report was written.

If stimulant medications and sleep agents were rightly removed from this analysis, the use of psychotropic medication use at NBYDC would fall to a more accurate 48 percent which is considerably lower than the national average.

Conclusion

The safety, effective treatment and overall well-being of our youth is DYRS' highest priority. This includes ensuring the proper medically managed treatment for youth that is responsive to their individual needs. When psychotropic medication is needed for a youth's individualized treatment, the agency strives to employ policies and procedures that align with national standards of care and best practice.

Again, thank you for the opportunity to review and provide comments regarding the confidential draft of the follow up assessment and report. Please reach out with any follow-up questions that you may have. DYRS looks forward to a final report that considers the concerns and comments articulated in this letter to ensure that the report's methodology and data sources produce findings that are research sound and accurate.

Sam Abed
Director
DYRS