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Oregon Council of Child & Adolescent Psychiatry

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Date: February 28, 2021

To: Representative Anna Williams, Chair
Representative Gary Leif, Vice-Chair
Representative Ricki Ruiz, Vice-Chair
House Committee on Human Services Members

From: Ajit Jetmalani, MD
Oregon Council of Child and Adolescent Psychiatry

RE: Position statement on HB 2333 a bill which requires DHS to report information regarding prescription of psychotropic medications to children in foster care.

My name is Ajit Jetmalani. I am a Child and Adult Psychiatrist, Professor of Psychiatry and head of the division of Child Psychiatry at OHSU. In that capacity, I have a role as consultant to OHA and DHS. I am expressing opposition to HB 2333 as a representative of the Oregon Council of Child and Adolescent Psychiatry (OCCAP) and not in my role at DHS, OHA or OHSU. OCCAP is an organization for medical doctors trained to diagnose and treat mental disorders in children, adolescents, and adults using biological, psychological, and social approaches.

In 2009, the Oregon legislature passed House Bill 3114, which amended Oregon Revised Statute 418.571 concerning psychotropic medication for children in foster care. I have overseen implementation of this statute since that time with DHS and OSU pharmacy. We have robust and effective oversight of psychotropic prescribing for youth in foster care in Oregon. Our rates of psychotropic prescribing are some of the lowest in the nation for a number of reasons:

1. We convened a task force of stakeholders that included Youth Advocates, Family Advocates, Behavioral Health Providers, Child Psychiatrists, Pediatricians, and others to examine ways to ensure the appropriate use of psychotropics in this vulnerable population.
2. That task force identified the need for youth, foster parents, providers, and DHS workers to all be well informed about the impact of trauma on children's emotions and behaviors. To this end, we created tip sheets and trainings focused on trauma informed practices (including Collaborative Problem Solving).
3. We created trainings for youth, care givers and providers on psychotropic prescribing and how to participate in a productive office visit.
4. We then developed a robust pharmacy driven monitoring system that identified practices that called for further review of records and the potential need to speak to the prescribing providers.
5. We changed who could provide authorization for a prescription and in the beginning required district managers to sign request forms by the prescribing provider.
6. Recently we changed the practice so that now the DHS Nursing team reviews all requests for new prescriptions.
7. In the beginning, I reviewed cases with providers when necessary.

8. In recent years we developed a workflow with OPAL K (the Oregon Psychiatric Access Line about kids) Child Psychiatrists.
9. Here is our current practice:
   (a) We annually review all youth in foster care who are on psychotropic medications.
   (b) We review every new prescription request by providers the same day it is requested.
   (c) If there is a prescribing concern during an annual review, we request records and then if we remain concerned, arrange for the provider to speak with an OPAL K child psychiatrist. At that call, the child psychiatrist reviews the overall care of the youth and discuss non-medical strategies as well as alternatives to the current approach. This is a collegial process where the provider feels safe to discuss their case and the consultant provides advice and support.
   (d) For new prescriptions, we do not authorize the request if there are concerns and have the provider call OPAL K for a same or next day consult with the same process as described.

Our process is robust, effective, and collaborative with our providers. **Our prescribing rates are lower than most states in all categories.** Following this written testimony are a series of graphs showing the trend of psychotropic prescribing in Oregon (2009 data pulled from https://www.gao.gov/new.items/d12270t.pdf). I do not have any concerns about sharing our data as a whole, by county or CCO other than it will require administrative effort and numbers of prescriptions do not really tell much of a story on their own.

I am strongly opposed however to section 1 number 6b and c of this bill, which require publishing the name and contact information of providers and the numbers of children seen. I see this as a form of intimidation, perhaps unintended, and I fail to see any benefit to the children who are served. It suggests that medical treatment of mental health challenges requires a different lens than the delivery of other medical treatments, which is a highly stigmatized view.

I am not aware of any such requirements for listing providers name and contact information regarding prescribing antibiotics, insulin, vaccines, antihypertensives, birth control, etc..... The risk is to further reduce access to care (because providers will not wish to be identified this way, especially without of any context) and undermine a robust, biopsychosocial, trauma informed practice that goes ***well beyond*** what HB 3114 required in 2009. **Please remove section 1 number 6b and c if you feel that the rest of these reporting requirements are in the best interest of our children in foster care.**

I regret that I am not able to provide this testimony in person but would be happy to meet with Representative Bonham to discuss my views on HB 2333.

Sincerely,

Ajit N Jetmalani

Ajit N Jetmalani, MD on behalf of
Oregon Council of Child and Adolescent Psychiatry