The Frontline Reports column features short descriptions of novel approaches to mental health problems or creative applications of established concepts in different settings. Material submitted for the column should be 350 to 750 words long, with a maximum of three authors (one is preferred) and no references, tables, or figures. Send material to Francine Cournos, M.D., at the New York State Psychiatric Insti-tute (fc15@columbia.edu) or to Stephen M. Goldfinger, M.D., at SUNY Downstate Medical Center (smgoldfingermd@aol.com).

The A+KIDS Program

Medicaid programs have experienced considerable growth in antipsychotic prescribing, particularly of second-generation antipsychotic agents. As the use of antipsychotic medications has grown, so too has evidence about the effectiveness, appropriateness, and safety of these treatments in pediatric populations. A major concern is metabolic abnormalities, which have been shown to be poorly monitored for children who take antipsychotics. Combined with concerns regarding antipsychotic use for conditions where there is limited long-term evidence-based support, many Medicaid programs have restricted antipsychotic utilization in the pediatric population. Restrictive policies, such as prior-authorization requirements, may reduce spending for antipsychotic treatment but may also present a barrier to patients who need antipsychotic treatment for approved purposes, restrict provider choice of treatment, and fail to address issues of safety, including metabolic monitoring.

In the face of concerns regarding existing Medicaid policies to improve antipsychotic prescribing, the state of North Carolina recently implemented A+KIDS (Antipsychotics + Keeping It Documented for Safety), a novel program in that it retains access to antipsychotic treatments and provider choice in the prescribing process but uses a medication registry to document aspects of prescribing. The primary goals of A+KIDS are to discourage unnecessary prescribing, to improve safety monitoring by educating providers and providing feedback about prescribing, and to minimize disruption to patient, caregiver, or prescriber. Key principles of A+KIDS are to be transparent and evidence based; to include involvement by all stakeholders, including professional associations, advocacy groups, mental health departments, and pharmacy representatives; to preserve open access to all antipsychotics; and to encourage best-practices monitoring for adverse effects.

A+KIDS was implemented in collaboration with Community Care of North Carolina, a managed care collaborative group with 1,500 medical home practices across the state. This infrastructure allowed for significant education to prepare providers and pharmacists for the A+KIDS implementation. In addition, a call center was available 40 hours a week to assist with registration, prescription denials, and problems.

A key feature of A+KIDS is the use of an online documentation tool (registry) for providers to register patients, track antipsychotic treatment, and document safety monitoring. A+KIDS was phased into use in three separate stages to minimize disruption. Provider registration began March 14, 2011, to collect information about provider specialty and practice characteristics. This was done in advance to ensure provider registration and allow for outreach to high-frequency providers most affected by the registry. Beginning April 12, 2011, the system began to capture clinical information for children age 12 and younger. Finally, on August 24, 2011, the system was released to capture safety monitoring data and open the program to adolescents ages 13 to 17.

A+KIDS is unique from traditional prior-authorization policies in that it does not restrict access to specific antipsychotic treatments or clinical conditions. The only criterion followed in the authorization process is prescriber entry of clinical and safety information. During initial prescribing, providers are asked to enter patient characteristics, the prescribed medication, the symptom targeted, and the primary diagnosis for treatment. Safety monitoring data collected by A+KIDS for patients who have received six months of treatment or longer include weight and height, potential daytime sedation, blood glucose monitoring, and lipid screening. Neurological side effects, including tremors, muscle stiffness, restlessness, and involuntary muscle movements, are also documented. Clinical and safety information is requested to be updated every six months for patients using antipsychotics for off-label conditions and annually for patients with U.S. Food and Drug Administration–approved indications. Prescribers maintain their ability to use clinical judgment as to whether a monitoring test is necessary and may use the tool to monitor patient progress. They have the option of stating that the monitoring is not clinically indicated and allowing a patient's family or guardian the choice to deny monitoring.

Traditional prior-authorization programs provide too blunt an instrument for managing a complex process in the prescribing of antipsychotic treatments. Novel approaches to improving evidence-based prescribing and monitoring of clinical safety for antipsychotic treatments are necessary to improve care. Preliminary monitoring of prescription dispensing in the North Carolina Medicaid population suggests a noticeable decline in antipsychotic prescribing to pediatric patients. Further program evaluation is planned to better understand the appropriateness of these declines and the potential for disruptions in patient care. In addition, an analysis will be conducted to determine the program's overall impact on cost savings. As Medicaid programs struggle with the complexity of this issue, the A+KIDS program provides a unique approach to

improving antipsychotic prescribing in the pediatric population.

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A Recovery-Oriented Money Management Intervention

Financial instability has been linked to increased risk of relapse, family burden and strain, substance abuse, and homelessness among people with serious mental illnesses. People with psychiatric disabilities often report not having enough money for basic necessities, and they consistently endorse financial management among their top personal goals. Financial well-being, on the other hand, is associated with greater quality of life, self-efficacy, and reduced psychiatric symptoms; therefore, financial management may be an important element of rehabilitation in this population. Studies of case management for people with psychiatric disabilities often include money management as a component due to its importance in living, social, and work environments. This report describes the outcomes of $teps for Achieving Financial Empowerment ($AFE), a recovery-oriented money-management intervention.

Seventy-seven adults volunteered to participate in the study. All had received a diagnosis of schizophrenia, bipolar disorder, or major depression and were receiving Social Security Administration benefits for psychiatric disability. Participants were recruited from mental health centers and state psychiatric hospitals in north-central North Carolina. Participants were administered the $AFE intervention, an individualized, psychoeducational intervention that teaches consumers with psychiatric disabilities how to save money, create a budget, avoid scams, access community resources, and work while receiving disability payments. Intervention length ranged from one-half hour to three hours, with a median of 1.5 hours.

Specifically, facilitators first review with disability recipients a list of ways to save money and which methods recipients have used in the past. Facilitators distinguish between expense needs (items needed to survive) and expense wants (items one wishes to buy), noting that if someone buys an item he or she wants but has not yet paid for expense needs, there is a risk of going into debt. Facilitators have disability recipients apply this principle to a budget exercise adapted from Boston University Center for Psychiatric Rehabilitation. Participants list income and expenses of a hypothetical case and are taught the fundamentals of creating their own budget. Next, using worksheets from the Social Security Administration (SSA), facilitators calculate how much disability income recipients can earn without losing disability benefits. Afterward, top strategies for avoiding financial exploitation from the National Fraud Information Center are reviewed, and participants are instructed that giving money for financial services as a result of a phone call, letter, Web advertisement, or TV advertisement raises risk of getting scammed. Finally, vocational and mental health resources in the community as well as the SSA Ticket-to-Work Program are described, along with steps for accessing community vocational rehabilitation.

Evaluation of the $AFE intervention consisted of baseline and six-month follow-up interviews regarding participants' financial capacity, demographic characteristics, living situation, and clinical history. Demographic interview questions included information regarding living situation and current employment. The Brief Psychiatric Rating Scale was used to measure psychiatric symptoms. Items from theMoney Mismanagement Measure were used to measure debt, savings, and implementation of a budget. The Empowerment Scale was used to measure perceived self-efficacy.

At six-month follow up, 96% of participants reported implementation of at least one new major financial management skill, and over half (57%) reported implementation of five or more new skills. The most frequently reported implemented skills were saving on utilities (51%), coupon use (61%), eating out less (68%), using a coin jar (65%), and managing a budget (64%). Over half (55%) reported a significant increase in savings as a result of skill implementation. Six-month follow-up interviews revealed other financial benefits as well. Compared with baseline, participants at six-month follow-up were more likely to be working at least part time, more likely to be saving money, less likely to report being in debt, and more likely to be using a budget. Multivariate analyses controlling for demographic and clinical variables revealed reduced psychiatric symptoms and increased self-efficacy at six-month follow-up.

Randomized trials with financial measures to corroborate participant self-report are needed to further investigate the efficacy of the intervention. Study findings suggest that interventions focusing on improving financial management skills can assist individuals with psychiatric disabilities better meet the basic needs and improve their global functioning. In addition, it suggests that such an intervention could provide a cost-effective approach to help consumers become less reliant on disability funds and increase their likelihood to work, helping them to gain independence and maximize societal integration.

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