Psychotropic Meds for Georgia Youth in Foster Care: Who Decides?

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Executive Summary

Youth in foster care are increasingly being prescribed psychotropic medications and increasingly being given multiple drugs at the same time. This has raised concerns among experts around the country. National organizations such as the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the Child Welfare League of America have taken positions on this issue, calling for experts to be involved in managing children's medications and asking states to implement oversight practices. Congress passed legislation requiring states to explain to the federal government how they are monitoring prescription medications for youth in foster care. Experts in child psychiatry and pharmacology have testified before Congress about the potential dangers to children from psychotropic medications. These experts explained common-sense solutions to protect the health of children in foster care.

The administration of psychotropic medications to youth in foster care raises several questions concerning the health and safety of children for whom the state is their legal parent:

1. Children in foster care do not have an involved parent who manages the child's health care and makes informed decisions about medications and treatment so who is performing this role for children in foster care?
2. Are the expensive Medicaid prescriptions being given to youth in foster care essential for optimizing their health? Are nonpharmacological treatments being considered for these youth instead of or in addition to medication?
3. How are these medicines, most of which do not have FDA approval for use in children, affecting the future health of youth in foster care?
4. Are children receiving appropriate pre-prescription mental and physical health assessments as well as proper follow-up and monitoring while taking psychotropic drugs?

The number of youth in foster care in Georgia who are receiving psychotropic medications has not been measured. Accurate information is not regularly compiled regarding the type and number of medications being prescribed to individual children, the number of children under the age of six who are receiving psychotropic medications, the type of ongoing medical and psychiatric care that is provided to youth who are taking psychotropic medications, and the cost to the state of these medications.

Many states around the country have addressed concerns about psychotropic medications for youth in foster care and Georgia should do the same. Georgia acts as parent for 7500 children who are in foster care because they are victims of abuse and neglect. Georgia should do everything possible to protect the health and safety of these children and ensure their future well-being.

Recommendations

1. Georgia needs to obtain accurate information about psychotropic medications and youth in foster care, including how many youth of what ages are receiving which medications for what purposes and at what costs.

2. Georgia needs to develop guidelines for the use of psychotropic medications for youth in foster care.
3. Georgia needs to develop a clear process for obtaining informed consent for the administration of psychotropic medications to youth in foster care. The process needs to be specific about who has authority to consent for a youth in foster care.
4. Georgia should develop one or more independent clinical teams that include a board-certified child psychiatrist to provide the following services:
    - individual case consultation to the state agency and prescribers;
    - training for those who work with youth in foster care;
    - independent review of all prescriptions for psychotropic medications that are written for youth in foster care before the prescription can be filled.
5. Youth in foster care should have a comprehensive mental health treatment plan that includes consideration of a variety of interventions and treatments that may include medications.
6. Georgia needs to establish quality assurance mechanisms to continuously improve all systems serving the mental health needs of youth in foster care and to hold all parts of the systems accountable.
7. The court system should help raise awareness about psychotropic drugs and youth in foster care.

I. Introduction

The state of Georgia has the awesome responsibility of serving as parent for some 7500 children in foster care. As the parent, Georgia is responsible for providing dinner, sneakers, pillows, jackets, toothbrushes, and pencils. Georgia is also responsible for making sure the children see dentists and doctors and sometimes mental health professionals. When a medication is needed, Georgia decides whether the child should have it. These tasks of daily living are carried out by state and county employees, contractors, foster parents, and volunteers.

Agreeing to well-child pediatric visits and vaccines that are required for school enrollment seem like routine decisions for a 25-year-old case manager with a bachelor's degree in social work. What about consenting to a 13-year-old taking an atypical antipsychotic medication in combination with an antidepressant and an ADHD drug? What level of expertise or what level of connection with a child does one need to make that kind of decision?

The Cold Case Project of the Supreme Court of Georgia Committee on Justice for Children says that decision must be made in consultation with an independent expert in child psychiatry.[1] The complexity of pharmacology and the lack of data about the long-term effects of psychotropic medications on children who are still rapidly growing dictate caution and specialized expertise when it comes to giving medications to children—particularly children whose parent is a government responsible for 7500 children.

In recent years, national awareness about the administration of psychotropic medications to youth in foster care has increased. Psychotropic medications have been the subject of Congressional hearings and front page stories in *The New York Times*. The prevalence of psychotropic medications among youth in foster care is estimated to be between 26% and 43%.[2] The rate of psychotropic medication use among the general youth population is 4%.[3] Youth in foster care are prescribed psychotropic medications at the same or greater rates than youth who are insured by Medicaid through Supplemental Security Income (SSI), and 3.4 to 4 times greater than the use of psychotropic medication among youth who are insured by Medicaid because of low family income.[4] In addition to a high number of youth in foster care being prescribed psychotropic medications, many of these youth receive multiple medications and some very young children (under age 6) are taking psychotropic medications.[5]

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[1] Applied Research Services, *The Georgia Cold Case Project*, 47 (2010). Recommendation # 12: "Provide independent oversight for children receiving mental health treatment," available at http://w2.georgiacourts.org/cj4c/files/The%20Georgia%20Cold%20Case%20Project_2010(1).pdf.

[2] Julie M. Zito, Daniel J. Safer, et. al., *Psychotropic Medication Patterns Among Youth in Foster Care*, Pediatrics, Vol. 121, No. 1, e157, e161 (January 2008) (a national prevalence rate does not exist and it is difficult to compare information across jurisdictions, time frames, and ages of youth taking the medications).

[3] Mark Olfson, Steven C. Marcus, et al., *National Trends in the Use of Psychotropic Medications by Children*, Journal of the American Academy of Child and Adolescent Psychiatry, Vol. 41, Issue 5, 514, 514 (2002).

[4] Zito, *supra* note 2.

[5] *Id.* at e157.

The high use of psychotropic medication among youth in foster care is of concern for many reasons. First, children in foster care do not have an involved parent who manages the child's health care and makes informed decisions about medications and treatment. Who is performing this role for children in foster care? Second, psychotropic medications are expensive and taxpayers, through Medicaid, are paying for them. Are the expenditures essential for optimizing the health of youth in foster care? Third, most psychotropic medications do not have FDA approval for use in children and the long-term health impact of psychotropic medications on children is not known. How are these medicines affecting the future health of youth in foster care? Finally, the foster care "system" makes appropriate management of medications and other mental health treatments difficult. Children in foster care have multiple placements, may see different providers, have incomplete medical records, may lack consistency in timing of medications and the amount that is ingested, and may not have a coordinated mental health plan that considers nonpharmacological treatments instead of or in addition to psychotropic medications. Are children receiving appropriate follow-up and monitoring of their physical and mental health when they are given psychotropic drugs?

Concerns about the use of psychotropic medications for youth in foster care are part of a larger national conversation about mental health treatment and the widespread use of prescription medications. The conversation about youth in foster care, however, raises three special concerns. The first is unique to youth in out of home placements: a child in foster care often does not have a consistent caregiver who is monitoring and advocating for the child's health needs. The US legal system, as it deals with decision-making by and for youth, is built around the premise that parents have Constitutional rights that allow them to make decisions for their children and that parents act in the best interests of their children. Youth in foster care usually do not have an engaged parent who is committed to protecting the child's mental and physical well-being. In many circumstances, youth in foster care don't have a single adult other than a health care provider who is meaningfully engaged in their mental health care.

The second special concern is not unique to youth in foster care, but is more common in this population: youth in foster care have greater mental health needs than most other youth populations.[6] Many have been exposed to multiple traumatic events, including horrific torture and rape and separation from the only people they have ever known. Because of their mental health needs, they are more likely to need psychotropic medications. However, they must have the same opportunities for the spectrum of appropriate services that are available to children who are in their parents' custody. Decisions to prescribe medications should be made with the same level of caution and benevolence that a dedicated parent would use.

The final special concern is applicable to all children and adolescents who are prescribed psychotropic medications: the lack of conclusive information about the long-term health effects

[6] "Studies indicate that 60-85% of the children being served by the child welfare system meet criteria for a DSM-IV Psychiatric diagnosis. In many cases this is related to the trauma that resulted in their removal from their family but in a significant number of cases the mental illness appears to have predated their removal." *Prescription Psychotropic Drug Use Among Children in Foster Care, Hearing before the Subcommittee on Income Security and Family Support of the House Committee on Ways and Means*, 110th Congress (May 8, 2008), testimony of Christopher Bellonci, M.D.

of these medications. Dr. Christopher Bellonci addressed this issue in his testimony before the House Subcommittee on Income Security and Family Support on May 8, 2008, saying,

> Most psychoactive medications prescribed for children under age twelve do not as yet have specific approval by the Food and Drug Administration (FDA); such approval requires research demonstrating safety and efficacy. Such research, so far, lags behind the clinical use of these medications. Long-term studies are needed to adequately determine the safety and efficacy of psychoactive medications in this age group. In making decisions to prescribe such medications child psychiatrists often are left to evaluate data from studies in adults even though there are documented cases of medications that were safe in adults causing unanticipated side-effects in children. The lack of data supporting current prescribing trends makes the informed consent process all the more important for children in state custody. The prescribing of multiple psychotropic medications ("combined treatment" or "polypharmacy") in the pediatric population is on the increase. Little data exist to support advantageous efficacy for drug combinations, used primarily to treat co-morbid conditions. The current clinical "state-of-the-art" supports judicial use of combined medications, keeping such use to clearly justifiable circumstances.[7]

Between 45% and 75% of psychotropic medications given to children and adolescents are prescribed off-label.[8] Almost none of the medications have FDA approval for use in children. Off-label use means that medications are prescribed in ways other than intended or approved by the FDA. Off-label prescribing is often the standard of care, but physicians must be well-informed and understand the benefits and risks of off-label use, as well as what to watch for in populations for which no studies exist.[9]

The number of youth in foster care in Georgia who are receiving psychotropic medications has not been measured. Georgia, as parent of these 7500 youth, does not know the type and number of medications being prescribed to individual children, the number of children under the age of six who are receiving psychotropic medications,[10] the type of ongoing medical and psychiatric care that is provided to youth who are taking psychotropic medications, and the cost to the state of these medications.

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[7] *Prescription Psychotropic Drug Use Among Children in Foster Care, Hearing before the Subcommittee on Income Security and Family Support of the House Committee on Ways and Means*, 110th Congress (May 8, 2008), testimony of Christopher Bellonci, M.D.

[8] Michael W. Naylor, et al., *Psychotropic Medication Management for Youth in State Care: Consent, Oversight, and Policy Considerations*, Child Welfare, Vol. 86, #5, 175, 178 (2007) and Julie M. Zito et al., *Off-Label Psychopharmacological Prescribing for Children: History Supports Close Clinical Monitoring*, 2 Child and Adolescent Psychiatry and Mental Health 24, 24 (2008).

[9] *Id*.

[10] Psychiatrists and pharmacology experts are particularly concerned about very young children receiving psychotropic medications because very few of these drugs have FDA approval for young children, studies do not exist to show the benefits of the off-label use compared to the risks, and scientists do not know how psychotropic medications may affect the rapidly developing brain of very young children.

Through its Cold Case Project, in 2009 the Georgia Supreme Court Committee on Justice for Children started hearing anecdotal evidence about youth in foster care who were receiving high doses of multiple psychotropic medications.[11] When this information was presented to the Committee, many Committee members (juvenile court judges, children's attorneys, parents' attorneys, service providers) shared that in their individual work, they saw what they felt was an overuse of psychotropic medication among youth in foster care. At about the same time, some Fellows in the child psychiatry program at Emory School of Medicine who were working with youth in Georgia's child welfare system began talking to policy makers, agency leaders, and service providers about some of their concerns about the administration of psychotropic medications to youth in foster care. Questions raised by the Cold Case Project and individual members of the Georgia Supreme Court Committee on Justice for Children led to conversations about how to best protect and promote the mental and physical health of children in foster care in Georgia.

Even without concrete numbers showing how many children are taking what types of medications, leaders in the child welfare, judicial, and mental health systems in Georgia agree that stronger protections are needed for youth in foster care. They agree that youth in foster care should only receive the psychotropic medications that they truly need and that these young people should have appropriate and ongoing medical care and mental health services prior to, while receiving, and while tapering off psychotropic medications.

This paper was prepared to facilitate conversations about the use of psychotropic medications by youth in foster care. It describes models from other states and makes recommendations for how Georgia should move forward. This paper is organized into four sections. Section II provides a national overview about this issue--what is known about psychotropic medication and youth in foster care and how some leading national organizations have been engaged. Section III describes the approaches other states have taken to address this issue. Section IV discusses recommendations for Georgia and the Committee on Justice for Children.

II. Overview

Attention to the growing use of psychotropic medications for youth in foster care is a recent development. Concerns by doctors, researchers, and policy makers have arisen within the last ten years. During that time, states have also begun to look at these issues and have taken steps to address identified problems. In the general population, the widespread use of psychotropic medications in children started after 1990 and the concurrent use of multiple psychotropic medications is even more recent.

[11] The Cold Case Project (2009-2010) was designed to examine cases of children who had been in foster care for more than two years with no connections to family and no identified prospects for a permanent home outside DFCS custody. The goal was to learn from these cases to improve permanency outcomes for all children in Georgia's foster care system. See http://w2.georgiacourts.org/cj4c/index.php?option=com_content&view=article&id=73&Itemid=67 for more information and the full project report.

In the last decade, with the rising awareness about possible dangers related to the use of psychotropic medications for youth, a few multi-state studies have been conducted; at least two rounds of Congressional hearings have occurred (in 2008 and 2010); several national organizations have issued policies, findings, and recommendations; federal legislation has been introduced to specifically address psychotropic medications and youth in foster care; the Fostering Connections to Success and Increasing Adoptions Act of 2008 (Fostering Connections Act)[12] was passed with provisions relating to health care; and national health care reform legislation has been enacted. This section discusses some of these developments.

A. Definitions

It is important for those discussing problems and solutions to use words that have the same meaning. Therefore, this section defines some terms commonly used in discussions around mental health issues. The most important term, for purposes of this paper, is "psychotropic medication." Stedman's Medical Dictionary defines "psychotropic" as "capable of affecting the mind, emotions, and behavior; denoting drugs used in the treatment of mental illnesses." Illinois, Florida, and other states have defined this term more specifically in their statutes or agency rules.[13] One report out of Florida says that there may be different understandings of the terms "psychotropic medications" and "psychotherapeutic medications," with the first term often referring to any chemical substances that affect mood, behavior, perception, consciousness (to include alcohol and illegal drugs).[14]

For purposes of this paper, the term "psychotropic medication" will be used consistently and the definition is a slight modification of the definition found in Oregon Revised Statutes Section 418.517(5)(b): a medication for which the prescribed intent is to affect or alter thought processes, mood or behavior, including but not limited to antipsychotic, antidepressant and anxiolytic medication and behavior medications. Unless otherwise indicated in this paper, "psychotropic medication" includes antipsychotic medications.

B. Studies

Several studies have been conducted to learn more about the administration of psychotropic medication to children and adolescents, and specifically to youth in foster care. The studies explore this issue within single states and across states, and examine policies as well as prescribing practices. There is not yet a single study that provides national data and recommendations. The studies described below provide insight into pieces of the national picture of psychotropic medication and youth in foster care. Taken together, there is enough information for experts to conclude that the use of psychotropic medications for youth in foster care is an area of great concern. More attention, information, and strategies are needed to ensure the health and safety of youth in foster care. The bibliography for this paper lists articles and resources,

[12] Public Law 110-351.
[13] 405 Ill. Comp. Stat. § 5/1-121.1 (2010), Fla. Admin. Code R. 65C-35.001(18) (2010).
[14] *Report of the Gabriel Myers Work Group* (November 19, 2009), page 8, available at http://www.dcf.state.fl.us/initiatives/GMWorkgroup/docs/GabrielMyersWorkGroupReport082009Final.pdf .

including a forthcoming law review article, that summarize additional studies and provide descriptions of how states are addressing this issue.

1. *Multi-State Study on Psychotropic Medication Oversight in Foster Care, 2010*

In September 2010, Tufts Clinical and Translational Science Institute released the report *Multi-State Study on Psychotropic Medication Oversight in Foster Care*, which provides "[a]n overview of the status of policies and guidelines for psychotropic medication oversight across 47 U.S. states and the District of Columbia in 2009-2010" along with "[d]escriptions of challenges and innovative solutions implemented by states."[15]

The report begins by saying that in the past decade, "psychotropic medication use in youth has increased 2-3 fold and polypharmacy (i.e., the use of more than one psychotropic medication at the same time) has increased 2.5-8 fold."[16] Additionally, the report states that the "rate of psychotropic medication use for youth in foster care" is estimated to be 13% to 52% higher than the rate of use in the general population of youth, which is currently around 4%.[17] There is great variation in the administration of psychotropic medication in foster care around the country, which raises concerns about the appropriate use of these medications for this population.

The study was conducted through phone surveys with agency leaders, medical directors, and agency staff; the phone interviews were augmented with policies and guidelines from the states. This study is particularly useful to states wanting to address the issue because it is short (24 pages including citations), well-organized and easy to read (bullet points, charts, clear headings), and includes an appendix that describes how states are addressing this issue with internet links to the tools states are using, such as provider manuals, informed consent protocols, medication guidelines, and agency policies. The appendix includes an extensive bibliography of websites and articles, organized by category. For example, the category called "Rates of Psychotropic Medication Use among Youth in Foster Care" lists 13 articles, 10 of which are dated 2005 and later.

2. *Antipsychotic Medication Use in Medicaid Children and Adolescents, 2010*

In June 2010, Rutgers University Center for Education and Research on Mental Health Therapeutics and the Medicaid Medical Directors Learning Network published *Antipsychotic Medication Use in Medicaid Children and Adolescents: Report and Resource Guide From a 16-*

[15] Laurel K. Leslie, et. al., *Multi-State Study on Psychotropic Medication Oversight in Foster Care*, Tufts Clinical and Translational Science Institute, September 2010, http://tuftsctsi.org/About-Us/Announcements/~/media/23549A0AA4DE4763ADE445802B3F8D6F.ashx.
[16] *Id.* at 1, citing several studies conducted over the last ten years.
[17] *Id.*

State Study.[18] While the report focuses only on antipsychotic (AP) medications and the study population includes all youth insured by Medicaid (not just youth in foster care), it contains a great deal of information that is instructive to states wanting to address psychotropic medication for youth in foster care.

The information in the study "represent[s] the combined results of analyses by the collaborating [s]tates of their claims for some 12 million children and adolescents in 16 [s]tates over four years (2004-2007)."[19] The goals of the collaborative effort

> "were to conduct exploratory analyses in each State on antipsychotic medication use rates and trends for children and adolescents in fee-for-service Medicaid using a comparable set of indicators that could 'flag' possible safety and quality issues; provide a forum for discussion of policies and programs for optimizing AP medication prescribing among States; and develop a compendium of State practices classified by the contributing States as mature, promising and emerging according to a consensually developed classification matrix created for this project by the project participants that could be shared with other States to address AP utilization issues."[20]

The study provides guidance on how states can collect AP medication data from Medicaid systems and includes a data dictionary and excel spreadsheet templates for collecting data. The information could easily translate to data collection for all psychotropic medications.

The study includes a separate document, *State Practices: 36 State Practices to Improve AP Medication Safety and Quality*, which includes detailed descriptions of many states' activities concerning AP, contact information for the responsible person within the states, and when available, information about the outcomes of these practices. The described practices often address wider issues related to psychotropic medication; they are not just limited to AP. Some examples of practices that are not limited to AP or could easily be applied to psychotropic medications include:

- Missouri has a system for prior authorization of ADHD Medications.[21]
- Massachusetts has the "Massachusetts Child Psychiatry Access Project" which provides telephone consultation services, continuing medical education, and an educational web site for physicians dealing with any kind of child psychiatry concern.[22]

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[18] *Antipsychotic Medication Use in Medicaid Children and Adolescents: Report and Resource Guide from a 16-State Study*. MMDLN/Rutgers CERTs Publication #1. July 2010. Distributed by Rutgers CERTs at http://rci.rutgers.edu/~cseap/MMDLNAPKIDS.html.

[19] *Id*. at 2.

[20] Medicaid Medical Directors Learning Network and Rutgers Center for Education and Research on Mental Health Therapeutics. *State Practices: 36 State Practices to Improve AP Medication Safety and Quality*, MMDLN/Rutgers CERTs, June 2010. Distributed by Rutgers CERTs at http://rci.rutgers.edu/~cseap/MMDLNAPKIDS/Antipsychotic_Use_in_Medicaid_Children_State_Practices.pdf, page 13.

[21] *Id*. at 71.

[22] *Id*. at 53.

- Washington's practices address all psychotropic medications and include using peer-to-peer statistical comparisons of prescribing practices, requiring generic medications to be used first, and developing ways to control off label use.[23]
- Maine uses an outreach approach called "Academic Detailing," an educational program in which trained clinicians visit doctors in their offices to provide information about prescribing practices and medications—the program is modeled after the approach of pharmaceutical companies sending reps to visit doctors and deliver samples and informational materials.[24] Academic Detailing in Maine has been successful in addressing diabetes and has just begun for AP medications.
- Another practice in Maine provides report cards to prescribers of antidepressants, letting them know about patient compliance with the prescriptions (based on pharmacy claims) and the number, cost, and types of prescriptions written by that prescriber.[25]

Georgia can look to this report to see the variety of approaches taken in 14 different states to encourage appropriate AP medication prescribing. The state "practices are categorized as policy, stakeholder engagement, education/marketing, patient-provider feedback, and system interventions."[26]

3. GAO Report, 2009

In February 2009, the Government Accountability Office (GAO) presented the report *Foster Care: State Practices for Assessing Health Needs, Facilitating Service Delivery, and Monitoring Children's Care* to the Chairman of the Subcommittee on Income Security and Family Support, Committee on Ways and Means, House of Representatives. GAO produced the study in response to Administration for Children and Families findings in the Child and Family Service Reviews that states were not performing well on health indicators. The Department of Health and Human Services was concerned about the health care needs of youth in foster care and requested a study to learn what states were doing to improve health services for this population. Ten states, California, Delaware, Florida, Illinois, Massachusetts, New York, Oklahoma, Texas, Utah, and Washington, were studied between November 2007 and January 2009. The study looks broadly at issues of health care, not just specifically mental health care, and in part looks at what states have done to implement provisions of the Fostering Connections Act that require states to improve oversight and coordination of health care services for youth in foster care. It highlights some promising practices that states have implemented regarding the administration of psychotropic medication.

GAO estimates that in 2004, state and federal expenditures on Medicaid for youth in foster care were well over $5 billion.[27] The study highlighted that the health care needs of youth in foster care are extensive: "Of the nearly 500,000 children in foster care at the end of fiscal year 2007, 80 percent are estimated to have significant health care needs, including chronic health

[23] *Id*. at 8.
[24] *Id*. at 49.
[25] *Id*. at 51.
[26] *Id*. at 2.
[27] US Government Accountability Office, *Foster Care: State Practices for Assessing Health Needs, Facilitating Service Delivery, and Monitoring Children's Care* (GAO-09-26), February 2009, page 16.

conditions, developmental concerns, and mental health needs."[28] The state practices highlighted in the study include financial incentives for physicians who treat youth in foster care,[29] the creation of an electronic "health 'passport' that electronically compiles data from multiple sources, including the state's immunization registry" and that can be updated by providers and others through a secure web site,[30] and different approaches to monitoring psychotropic medications.[31] Many of these approaches are described below in section III.

4. Psychotropic Medication Patterns Among Youth in Foster Care, 2008

One leading expert on the issue of psychotropic medication for youth in foster care is Dr. Julie M. Zito, PhD, Professor of Pharmacy and Psychiatry, University of Maryland. She has prepared studies for the Children's Bureau National Resource Centers, published findings from several studies, testified before Congress, and helped states improve their approach to mental health care for youth in foster care. She is the lead author of *Psychotropic Medication Patterns Among Youth in Foster Care*, published in 2008 in *Pediatrics*, which concluded that the administration of multiple psychotropic medications to youth in foster care is frequent and there is a lack of "substantive evidence as to its effectiveness and safety."[32] The purpose of the study was to describe and quantify prescription patterns for psychotropic medications among a sample of youth in foster care.

The study looked at a random sample of 472 youth in foster care in Texas who were prescribed psychotropic medication in July 2004. In this study, 41.3% of youth received three or more psychotropic medications, 23 children were age 4 or younger, and 104 children were in the age group 5-9.[33] The study states that true comparisons of the prevalence of psychotropic medications among youth in foster care and other youth who are insured through Medicaid are difficult to obtain because the studies have not been done. Likewise with youth in foster care compared to youth in the general population. However, based on information that is available, the study stated that psychotropic medication prevalence among youth in foster care ranges from 25.8% to 43% and that "[c]ompared with nonfoster care Medicaid enrollees, psychotropic drug treatment in the foster care population now equals or exceeds that of eligible youth in the SSI group and is 3.5- to fourfold more prevalent than in Medicaid-insured youth eligible by low family income."[34]

Texas Comptroller Carole Keeton Strayhorn commissioned the study that led to the Zito article because she wanted an external review of Medicaid prescription data for youth in foster care. In 2004, Strayhorn published a report strongly criticizing Texas' foster care system and calling for a number of reforms.[35] That study highlighted problems with the administration of psychotropic

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[28] *Id*. at 1.
[29] *Id*. at 24 (Illinois and Washington).
[30] *Id*. at introduction (Texas).
[31] *Id*. at 28-30 (Illinois and Washington).
[32] *Psychotropic Medication Patterns Among Youth in Foster Care*, *supra* note 2, at e157.
[33] *Id*. at e158 and e160.
[34] *Id*. at e161.
[35] Strayhorn, Carol Keeton, *Forgotten Children, A Special Report on the Texas Foster Care System* (April 2004), available at http://www.scribd.com/doc/38352706/Carole-Keeton-Strayhorn-Texas-Comptroller-Forgotten-Children-2004.

medications to youth in foster care and led Strayhorn to publish a special report in 2006 that focused on medications for youth in foster care.[36] Both reports led her to ask the Texas Office of Inspector General at the Health and Human Services Commission to investigate possible fraud and abuse among Medicaid Providers.

The comptroller's studies may be instructive for Georgia in terms of analyzing the issues and developing models for changes. Texas has addressed the issue of psychotropic medications for youth in foster care from a variety of angles, and the information available indicates subsequent improvements in management of mental health issues and prescription practices.

In other work that she has done, Dr. Zito has found that among youth with either Medicaid or HMO insurance, the use of psychotropic medication increased two to three times in the decade between 1996 and 2006.[37] While the use of psychotropic medications has dramatically increased for all youth, the increase in prescriptions for preschoolers is particularly dramatic: between 1995 and 2001, for Medicaid-insured preschoolers in seven states, the use of antipsychotic medication increased five times and the use of antidepressants doubled.[38] In addition to the overall increase in the use of psychotropic medications for children, Dr. Zito found that the use of more than one psychotropic medication for children is a very new development—polypharmacy for children was rarely practiced before the 1990s.[39] In general, there are more health impairments among children insured by Medicaid than among those on private insurance and there are more health impairments among children in foster care than among other children insured by Medicaid.[40] Studies of the prevalence of mental health needs of youth in foster care estimate that 50% to 80% of youth in foster care suffer from a serious emotional or mental health disorder.[41]

5. *Psychotropic Medication use in Medicaid Eligible Children, study in progress*

The PolicyLab: Center to Bridge Research, Practice, and Policy at the Children's Hospital of Philadelphia Research Institute is currently conducting a study on "psychotropic medication use in Medicaid eligible children."[42] The study looks at the ten largest states in the United States and examines a number of issues around the administration of psychotropic medication to youth, including informed consent, variations in use across states and populations of children, atypical

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[36] Strayhorn, Carol Keeton, *Texas Health Care Claims Study—Special Report on Foster Children* (December 14, 2006), available at http://www.window.state.tx.us/specialrpt/hccfoster06/hccfoster06_revised.pdf

[37] *Prescription Psychotropic Drug Use Among Children in Foster Care, Hearing before the Subcommittee on Income Security and Family Support of the House Committee on Ways and Means*, 110th Congress (May 8, 2008), testimony of Julie Magno Zito, Ph.D.

[38] *Id.*

[39] *Id.*

[40] *Id.*

[41] *E.g.*, Julie S. Steele and Karen F. Buchi, *Medical and Mental Health of Children Entering the Utah Foster Care System*, Pediatrics, Vol. 122, No. 3, e703 (September 2008).

[42] http://policylab.us/index.php/research-and-policy/child-welfare/81-psychotropic-drug-use-in-foster-care-.html, accessed 11/8/2010.

use of psychotropic medication, and the health risks of psychotropic medications among different populations of children. One goal of the study is to "[g]enerate an evidence-base for atypical antipsychotic use in pediatric populations and in turn inform program policies that promote effective and safe practices for children."[43] The lead researcher on the project is David M. Rubin, MD, MSCE, and there is no estimated date for release of the study findings.

C. Organizations

Several national organizations that are considered to be experts on children's health and welfare have issued standards or recommendations on best practices for providing health services for youth in foster care. Some of the standards address health issues broadly and some are specific to psychiatric care. National experts at the forefront of their fields developed the standards which are based on current research and represent best practices. The Child Welfare League of America (CWLA), the American Academy of Pediatrics (AAP), and the American Academy of Child and Adolescent Psychiatry (AACAP) all recommend that every child should receive a mental health screening when placed into foster care and receive a comprehensive mental health assessment by a mental health professional as part of a comprehensive evaluation within a month of being placed into foster care. Each of these organizations has put forward standards which outline the need for a systematic, coordinated approach to the delivery of mental health services to meet children's ongoing mental health needs.

Federal law also recognizes the need to provide appropriate health care for youth in foster care. The Fostering Connections Act requires states to develop a plan for "the ongoing oversight and coordination of heath care services for any child in a foster care placement"[44] that will "ensure a coordinated strategy to identify and respond to the health care needs of children in foster care placements, *including mental health*…."[45] Pediatricians and other health care experts are to be involved with developing the state plan and the plan has to include information about how the state will provide for "*the oversight of prescription medicines*…."[46]

1. Child Welfare League of America

The CWLA is a leading national advocacy organization working on sound public policies for safety, permanence, and well-being for abused children. CWLA collaborates with other organizations possessing subject-matter expertise to develop standards to guide professionals working in this field. In 1988, CWLA worked with the AAP to develop *Standards for Health Care Services for Children in Out-of-Home Care*. In 1997 the child mental health division of CWLA was formed following the merger of the American Association of Psychiatric Services for Children with CWLA. In 2003, CWLA established a *Best-Practice Framework for Addressing the Mental Health and Substance Abuse Needs of Children and their Families*. In 2007, CWLA released an updated and revised *Standards of Excellence for Health Care Services for Children in Out-of-Home Care*. CWLA has also worked with the Robert Wood Johnson Foundation to convene summits on the behavioral health needs of vulnerable families, leading to

[43] *Id.*
[44] 42 U.S.C. § 622(b)(15)(A).
[45] *Id.*, emphasis added.
[46] *Id.*, emphasis added.

the publication of *Integrating Systems of Care: Improving Quality of Care for the Most Vulnerable Children and Families*.

2. American Academy of Pediatrics

Attaining "optimal physical, mental, and social health and well-being for all [children]" is the mission of the AAP, a membership organization of over 60,000 pediatricians in several countries.[47] The AAP has a Task Force on Foster Care which includes members from other national organizations as well as AAP doctors. With partner organizations, the AAP created an initiative called Healthy Foster Care America "to improve the health and well-being outcomes of children and teens in care."[48] The web site for this initiative contains a wealth of resources for adults working with youth in foster care. In addition to the fact sheets, FAQs, policy statements, and other information available through the web site, the AAP has published *Fostering Health: Health Care for Children and Adolescents in Foster Care* (2004), *Health Care of Young Children in Foster Care* (2002), *Developmental Issues for Young Children in Foster Care* (2000), and *Identification and Care of HIV-Exposed and HIV-Infected Infants, Children, and Adolescents in Foster Care* (2000).

The AAP has adopted several policy statements addressing the mental health needs of children and the specific needs of youth in foster care. The policy statements include *Developmental Issues for Young Children in Foster Care* (2000) and *The Future of Pediatrics: Mental Health Competencies for Pediatric Primary Care* (2009). In addition, the AAP has endorsed some of the policy statements of the American Academy of Child and Adolescent Psychiatry that address youth in foster care.

In addition to formal policy statements, the AAP, through its Healthy Foster Care America web site, provides a list of accepted guidelines for physicians prescribing psychotropic medications to children in foster care. The guidelines include requiring the child to have a mental health evaluation by a trained pediatric mental health professional prior to starting medications; developing a mental health treatment plan that includes non-pharmacological treatments in addition to or instead of psychotropic medications; and providing low doses, close monitoring, and periodic reviews of medications.[49]

The AAP also has a section of its web site devoted to "Children's Mental Health in Primary Care," which contains *Strategies for System Change in Children's Mental Health: A Chapter Action Kit*, developed by the AAP Task Force on Mental Health.[50]

3. American Academy of Child and Adolescent Psychiatry

"The AACAP is a professional medical organization comprised of child and adolescent psychiatrists trained to promote healthy development and to evaluate, diagnose, and treat children and adolescents and their families who are affected by disorders of feeling, thinking,

[47] http://www.aap.org/visit/facts.htm, accessed 11/7/2010.
[48] http://www.aap.org/fostercare/about.html, accessed 11/7/2010.
[49] http://www.aap.org/fostercare/mental_behavioral_health.html, accessed 11/7/2010.
[50] http://www.aap.org/mentalhealth/mh2ch.html, accessed 11/7/2010.

learning, and behavior."[51] The AACAP has issued several policy statements on the use of psychotropic medications in youth and on the specific needs of youth in foster care. The most important one for this paper is the 2005 *AACAP Position Statement on Oversight of Psychotropic Medication Use for Children in State Custody: A Best Principles Guideline*. The position statement was developed in part to help states develop programs for monitoring psychotropic medication prescriptions for youth in foster care. One concern of the AACAP is that consent, authorization, and monitoring processes set up by states "often have unintended consequences such as delaying provision of or reducing access to necessary medical care."[52]

The AACAP position statement contains basic principles, including that youth in foster care should:

- be screened for behavioral disorders and if indicated, receive a comprehensive psychiatric evaluation;
- have effective and continuous mental health services;
- have access to a variety of effective behavioral health interventions and treatments which may include pharmacotherapy;
- have a sensible consent procedure; and
- have appropriate medication management.[53]

The position statement recommends that entities with authority to consent to medications (such as courts and child welfare agencies) should work with child and adolescent psychiatrists to establish policies about psychotropic medication for youth in foster care. The position statement describes the elements of an appropriate consent process, which includes training for all persons working with these youth, an effective oversight process, and an effective consultation program. One recommendation is that states (or agencies or courts) establish web sites to provide accurate information for all who need it. Several states and non-governmental organizations have established such web sites, so there are many examples for Georgia to emulate.[54]

In 2009, the AACAP published *Practice Parameter on the Use of Psychotropic Medication in Children and Adolescents*, which the lead author, Dr. John Walkup, describes as "a call for action to create a systematic and comprehensive approach to using medications in children safely and effectively."[55] The parameters consist of 13 principles for best practices, which include obtaining a complete psychiatric and medical evaluation of the child, developing an appropriate psychosocial and psychopharmacological treatment plan, and obtaining appropriate informed consent from the parent or guardian and assent of the youth.

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[51] http://www.aacap.org/cs/root/about_us/mission_statement, accessed 11/7/2010.
[52] *AACAP Position Statement on Oversight of Psychotropic Medication Use for Children in State Custody: A Best Principles Guideline*, 2005, available at http://www.aacap.org/galleries/PracticeInformation/FosterCare_BestPrinciples_FINAL.pdf.
[53] *Id*.
[54] *E.g.*, http://centerforchildwelfare.fmhi.usf.edu/mhsa/default.aspx, http://www.psych.uic.edu/csp/home/mission.html, http://www.dshs.state.tx.us/mentalhealth.shtm, http://www.guardianadlitem.org/resources_psychotropic_quick_reference.asp.
[55] Mark Moran, *AACAP Document Guides Clinicians in Best-Practices Prescribing*, Psychiatric News, Vol. 44, No.20, 2 (October 16, 2009).

Other relevant policy and position statements issued by the AACAP include *Prescribing Psychoactive Medication for Children and Adolescents* (2001), *Psychiatric Care of Children in the Foster Care System* (2001), *AACAP/CWLA Foster Care Mental Health Values* (2002) (also endorsed as policy by the AAP), and *Screening and Assessment of Children in Foster Care* (2003) (also endorsed as policy by the AAP). These policies include recommendations that youth in foster care receive comprehensive medical and mental health assessments soon after entering care and that mental health treatment should include a full range of intervention and treatment, including nonpharmacological approaches when indicated. *Pharmaceutical Benefit Management and the Use of Psychotropic Medication for Children and Adolescents* (2009) is another related policy statement. It reaffirms the AACAP position that child psychiatrists' decisions about prescribing medications should not be restricted or dictated by insurance companies and policy makers, and should not require pre-authorization for certain formulary choices.

III. Approaches

This section describes what some states are doing to ensure that youth in foster care who need psychotropic medication receive the most appropriate medication in a timely manner and with proper monitoring, follow-up, and related mental health supports. Because states have only recently become aware of concerns about psychotropic medications and youth in foster care, most changes that states have made regarding prescriptions for youth in foster care have been implemented since 2005.

Since this is such new territory, mental health experts and policy makers don't yet know which approaches will yield the best results over time. As Georgia considers how to address this issue, it is important to note that there is not a single identified "best practice" for oversight of psychotropic medication for youth in foster care. Several promising practices have been tried but there is no long-term research on the effectiveness of these approaches and no consensus among experts in the field. What does appear to be true, though, and should provide a great incentive for Georgia to move forward, is that any attention that is paid to this issue seems to make a positive difference. For example, in states that implemented voluntary standards for the administration of psychotropic medication for youth in foster care and then measured the impact of the standards by reviewing Medicaid claims, the use of psychotropic medication declined and the rate of polypharmacy also declined.[56]

A. Avenues for Change

The approaches taken in other states are primarily implemented through these three avenues: promulgation of agency policy; collaboration of stakeholders; and passage of legislation. The

[56] *E.g.*, Texas Health and Human Services Commission, *Update on the Use of Psychoactive Medications in Texas Foster Children Fiscal Years 2002 – 2009*, http://www.hhsc.state.tx.us/medicaid/OCC/psychoactive_medications.html, and Florida Medicaid Prescribed Drug Program Policy Review: *Oversight of Off-Label Prescribing of Atypical Anti-Psychotic Medications for Children Under Six Years of Age Covered by the Florida Medicaid Program* (March 27, 2009), http://centerforchildwelfare.fmhi.usf.edu/mhsa/PsychMeds/FlMedicaid-OversightOff-LabelMeds2009.pdf.

most common approach is the development of agency policy or regulations. This approach allows those who have the most information about the issue to work out the details of how to address it. Generally speaking, promulgating agency regulations allows stakeholders to have a more direct role in developing the details of solutions than the legislative process might allow. Also, agency regulations and policies are easier to adapt to changing information and circumstances than are laws. The decision about which agencies need regulations for psychotropic medication must be made according to each state's systems. In some states the regulations about psychotropic medication for youth in foster care are made by and govern the agency responsible for the foster care system, and in some states the policies are made by and govern the agency responsible for providing mental health services to youth in foster care. For purposes of this paper, information was not collected about the manner in which policies on this issue are promulgated, such as whether policies go through a public review process required by an administrative law act or are promulgated internally without public scrutiny.

Another avenue for implementing changes in this area is through collaborations of state or local agencies and private organizations. External pressure can be brought on the system through work groups, Governor's commissions, and task forces. Sometimes these are the result of litigation, such as in Tennessee, or a tragedy, such as the Gabriel Myers work group in Florida.[57] This approach has the potential for greater involvement of stakeholders than rulemaking or legislation. It can be a powerful approach because theoretically, the stakeholders and those responsible for implementing the recommendations participated in developing them and are vested in the successful implementation of improvements. Drawbacks to this approach are that task forces rarely have the authority to force systems and individuals to change, to access funding and other resources needed for wide-scale improvements, or to enforce compliance with agreements and implementation of recommendations. Without a champion who has authority to make changes, recommendations are often just recommendations and not action plans.

The third avenue that states often use is passage of legislation addressing the administration of psychotropic medication. Legislation can be used to facilitate a process by requiring agency action and setting the parameters and outcomes of the action. For example, in 2009 Oregon passed legislation that started with this sentence, "The Department of Human Services shall develop by rule procedures for the use of psychotropic medications for children placed in foster care by the department."[58] The legislation then proceeded to describe what the department's rules must address. Legislation can also dictate the process directly. Because of the details involved in setting up processes for handling the administration of psychotropic medication and the rapid speed at which the medical, psychiatric, and child welfare fields develop, legislation can be an imprecise tool for addressing the details of how service providers should medicate children. However, since legislation mandates action, it is an effective mechanism to create changes.

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[57] *See Brian A. v. Bredesen* (http://www.childrensrights.org/reform-campaigns/legal-cases/tennessee-brian-a-v-bredesen/2/), http://www.dcf.state.fl.us/initiatives/GMWorkgroup/index.shtml, and http://www.tampabay.com/news/health/medicine/article1005344.ece.

[58] Oregon House Bill 3114, 75th Oregon Legislative Assembly, 2009 Regular Session, codified at Oregon Revised Statutes § 418.517 (2010).

In states that have addressed psychotropic medication in legislation, the legislation often requires the agency or agencies to do one or more of the following: promulgate rules around psychotropic medication for youth in foster care, create an oversight process, and publish guidelines for prescribing psychotropic medications to youth in foster care. The legislation can include dates by which these things need to be completed and can require agency heads to report about their progress to the legislature. The legislation establishes the framework for the changes, rather than dictating the terms of the oversight process or practice parameters.

Framework-setting legislation can be used for system-wide changes or it can be used to address the specific issue of psychotropic medications for youth in foster care. In Texas, legislation mandated a complete overhaul of health care services for youth in foster care, stating "[t]he commission shall collaborate with health care and child welfare professionals to design a comprehensive, cost-effective medical services delivery model, either directly or by contract, to meet the needs of children served by the department."[59] The statute lists the components that the medical services delivery model must include. In Connecticut, legislation required the Department of Children and Families to "(1) establish guidelines for the use and management of psychotropic medications with children and youths in the care of the Department of Children and Families, and (2) establish and maintain a database to track the use of psychotropic medications with children and youths committed to the care of the Department of Children and Families."[60]

The paragraphs above describe *how* states address concerns and solutions related to the administration of psychotropic medications for youth in foster care. The paragraphs below describe *what* the solutions are—the subject matter of the rules, collaborative initiatives, and legislation. The solutions tend to fall within these three topic areas, medication parameters, consent, and oversight and tracking, with each of these topic areas including several subtopics to consider.

B. Medication Utilization Parameters

Many states that have addressed the issue of psychotropic medication for youth in foster care have found it essential to first develop guidelines about acceptable prescribing practices. These are most often called "medication guidelines" or "utilization parameters" and they create a range of prescription practices that a skilled peer group of child psychiatry and mental health experts agree is acceptable. They also identify prescribing practices that require additional consideration, such as additional study of the patient's case, consultation with additional experts, or prior authorization by Medicaid. They are often called parameters because prescriptions that fall outside the boundaries that are established, such as a prescription for antipsychotics for a three-year-old, should be carefully examined for medical necessity, safety, and age-appropriateness. The list of prescribing practices requiring additional consideration is often called a "red flag" list or "red flag markers" because they indicate prescribing practices outside of normal trends.

Several states have developed guidelines or parameters and the AACAP has published *Practice Parameter on the Use of Psychotropic Medication in Children and Adolescents* that contains thirteen principles for best practices. Enough work has been done in this area that the general

[59] Tex. Fam. Code § 266.003 (2010).
[60] Conn. Gen. Stat. § 17a-21a (2010).

framework exists and can be adapted to any state. Most of the states that have developed utilization parameters have made them available on the internet for other states to use.[61] The most common approach states have taken to develop utilization parameters is convening experts in the state to work out the details of what should be in the guidelines. Experts should include child psychiatrists, pharmacologists, child psychologists and representatives from some of the key child psychiatry stakeholder groups in the state. It can also be helpful to include someone who is familiar with the operations of the state agencies who will be working with providers to implement the guidelines. Texas and Tennessee included professors from the medical schools, national experts, and representatives from the state psychiatric and physician organizations in their processes.

Drug utilization parameters can be mandatory, meaning that any provider prescribing medications for youth in foster care must follow them, or they can be voluntary, meaning they exist to promote best practices in prescribing and providers are encouraged to follow them but are not required to do so. Even when the parameters are mandatory, they are not used in lieu of the sound medical judgment of experienced practitioners. Instead, they set up a process in which certain decisions of providers are routinely reviewed—that is, when a provider writes a prescription that falls outside the parameters, that prescription triggers a review process of some kind.

1. Mandatory drug utilization parameters

In mandatory systems, a prescription falling outside the parameters triggers an oversight event. Oversight is described more fully in section III.D below. States mandating drug utilization parameters can set up different ways to trigger reviews of prescriptions that fall outside the parameters. One approach is incorporation of the parameters into contracts with service providers, including individual service providers and managed care organizations.[62] An important component of an effective oversight system is educating those whose decisions may be reviewed. All providers who may be involved in the child's health care need to be informed

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[61] *E.g.*, Connecticut Department of Children and Families Psychotropic Medication Advisory Committee *Guidelines for Psychotropic Medication Use in Children and Adolescents*, Jan. 2010, http://www.ct.gov/dcf/lib/dcf/behavorial_health_medicine/pdf/guidelines_psychotropic_medication.pdf, Illinois Department of Children and Family Services *Guidelines for the Utilization of Psychotropic Medications for Children in Foster Care*, http://www.psych.uic.edu/csp/physicians/Medication%20Guidelines.pdf, New Jersey Department of Children and Families Office of Child Health Services *Psychotropic Medication Policy*, Jan. 2010, http://www.state.nj.us/dcf/behavioral/providers/PsychotropicMeds.pdf, Tennessee Department of Children's Services Pharmacy and Therapeutics Committee *Psychotropic Medication Utilization Parameters for Children in State Custody*, http://www.state.tn.us/youth/dcsguide/policies/chap20/PsychoMedUtilGuide.pdf.

[62] *See e.g.*, Tennessee Department of Children's Services Administrative Policies and Procedures: 20.18(D): "The Department requires all mental health contracting facilities to utilize the Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) Best Practice Guidelines for Behavioral Health Services for Children and Adolescents when making treatment decisions, including the prescribing of psychotropic medication, for children/youth in custody. Available at http://www.tn.gov/youth/dcsguide/policies/chap20/20.18.pdf.

about the utilization parameters—what they mean, how they are being implemented, and what that provider's role is in ensuring appropriate mental health services for youth in foster care.

2. Voluntary psychotropic prescription guidelines

Drug utilization parameters do not have to be part of a formal oversight system to improve prescribing practices. In states where guidelines were developed and were recommended but not mandated, the use of psychotropic medications for youth in foster care declined after the creation and dissemination of the voluntary guidelines. For example, in Texas, the voluntary guidelines were widely disseminated to Medicaid providers in February 2005. Using Medicaid claims data, prescribing patterns were examined for September 2004 – January 2005 and April 2005 – August 2005. In the five months after the distribution of the guidelines, use of multiple medications within a drug class decreased by 28.7%, use of five or more medications concurrently decreased by 30.9%, and prescriptions of psychotropic medications to youth without a mental health diagnosis decreased by 21.8%.[63]

One reason the Texas parameters were effective was the inclusion of many stakeholders and respected experts in the process of developing the parameters. Another reason was the wide dissemination of the parameters. The parameters were sent to all Medicaid providers with an explanatory letter from the Commissioner of the Texas Department of Health Services.[64] The one-page letter explained what the guidelines were, that they were voluntary and a valuable resource for treating all children with mental health disorders (not just Medicaid patients), and encouraged physicians to consult the guidelines. The letter clearly stated that there would be no penalty for not following the guidelines but stated that departure from the guidelines should be documented in the child's medical record. The Connecticut Guidelines were distributed with a similar cover letter from the Department of Children and Families Medical Director.[65] The Texas parameters were updated in December 2010 and have been incorporated into the Star Health managed care organization so they are now mandatory for providers; a prescription that falls outside the parameters triggers a review by the Star Health medical director or a child psychiatrist.[66]

C. Consent

The area most often addressed by policy and statute is the question of who can consent to what medications for a youth in foster care, and what constitutes informed consent. The concept of

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[63] Texas Health and Human Services Commission, Department of State Health Services, and Department of Family Protective Services, *Use of Psychoactive Medication in Texas Foster Children State Fiscal Year 2005* (June 2006), page 7, http://www.hhs.state.tx.us/news/release/Analysis_062306.pdf.

[64] Available at http://www.dshs.state.tx.us/mhprograms/pdf/PsychotropicMedicationLetter_020107.pdf, accessed 11/8/2010; *Parameters* were updated December 1, 2010 and are available at http://www.dfps.state.tx.us/documents/about/pdf/TxFosterCareParameters-December2010.pdf.

[65] Available at http://www.ct.gov/dcf/lib/dcf/behavorial_health_medicine/pdf/guidelines_psychotropic_medication.pdf.

[66] *See, e.g.*, http://www.dfps.state.tx.us/About/Renewal/CPS/medical.asp, accessed 11/8/2010, http://www.dfps.state.tx.us/documents/about/pdf/2009-03-09_STARHealth-PMUR-FAQ.pdf, accessed 12/30/2010, and *State Practices: 36 State Practices to Improve AP Medication Safety and Quality*, *supra* note 20.

consent for medical care for youth in foster care is distinct from consent to medical care in any other context. Children who are not in foster care have parents or guardians who provide consent for medications; this is an established right of parents in the Unites States of America and parents are assumed to act in the best interests of their children.[67] Adults who cannot consent to their own medications are impaired in some way—some states consider these "persons with a disability" or "persons who are incompetent."[68] Adults who are legally prohibited from consenting to their own medical care usually suffer from mental illness, a debilitating disease or medical condition, or they have a developmental disability. Youth in foster care are not disabled or incompetent in the same way as are adults who have medical guardians, and at the same time they do not have a committed parent or guardian who is looking out for their medical interests and managing their health care. They are uniquely vulnerable to decisions being made that are not in keeping with what is best for them. Therefore, the question of who can consent to their medical care is of particular importance.

Inseparable from the concept of consent is the question of how the person with authority to consent makes the decision. The consent must be "informed," but what level of information is sufficient for informed consent on behalf of a youth in foster care? A related question is what happens when there is disagreement about whether consent should be given. Who should have the ultimate authority to decide whether a 14-year-old in a group home should take four different psychotropic medications concurrently?

The most direct way that states establish the consent process is through rules or laws that specify exactly who can consent to the administration of psychotropic medication in what situation and specify the process for obtaining consent. Another approach is to use the process already established for providing medical care to youth in foster care and include or exclude "psychotropic medication" in the definition of "ordinary medical care," either in statute or in agency policies. In most states, like in Georgia, the agency has authority to consent to "ordinary medical care" and consent for other procedures remains with the birth parents or guardian until their rights have been legally terminated.[69] Most states do not define "ordinary medical care," but a few have begun to define the term and either include psychotropic medication within the definition or specifically exclude it.[70]

Regarding what constitutes "informed consent," some states define the term in statute or in regulation. In Florida, "'[e]xpress and informed consent' means consent voluntarily given in writing, by a competent person, after sufficient explanation and disclosure of the subject matter involved to enable the person to make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion."[71] In Arizona, the

[67] *Parham v. J.R.*, 442 U.S. 584, 602 (1979).
[68] *E.g.* Wash. Rev. Code § 11.88.010(e) (2010) "For purposes of giving informed consent for health care …, an 'incompetent' person is any person who is (i) incompetent by reason of mental illness, developmental disability, senility, habitual drunkenness, excessive use of drugs, or other mental incapacity, of either managing his or her property or caring for himself or herself, or both, or…."
[69] *E.g.*, Ga. Code § 15-11-13 (2010), La. Children's Code Art. 116 (2010).
[70] *E.g.*, Okla. Stat. tit. 10A, § 1-3-102 (2010).
[71] Fla. Stat. § 394.455(9) (2010).

Department of Health Services Practice Protocol lists the essential elements of informed consent.[72]

States that have specific consent requirements have exceptions for emergencies. States often define what constitutes an emergency and provide procedures for getting medication to a youth when it is not possible to obtain the required informed consent in advance. The exceptions may include obtaining consent within a specified time period after the emergency administration of medication.

1. Consent by parent or guardian

As stated above, the authority of parents to consent to medical care for their children is a well-recognized and much-litigated right. When a child is adjudicated dependent or deprived, the child's parents lose many of their rights to make decisions about the daily care and control of the child, including decisions relating to ordinary medical care. States have different approaches to the level of involvement a parent must and may have in the provision of medical care, including mental health care, to a child who has been placed in state custody.

States in which parents retain the right to consent to psychotropic medications have varying approaches to parental involvement. Florida, for example, has an extensive statutory and regulatory scheme for parental consent. Florida requires the agency to make significant efforts to help the prescribing doctor obtain parental consent before psychotropic medication can be prescribed and the efforts must be thoroughly documented.[73] In addition to the laws and formal administrative rules, Florida also has agency policies on the issue and Rules of Juvenile Procedure for the courts.[74] Parents in Florida retain the right to consent to psychotropic medication until their parental rights are terminated or a judge overrides their consent after a hearing. The agency, in consultation with the doctor, can ask the judge to override a parent's decision when consent cannot be obtained from the parent or when the agency disagrees with the parent's decision about consent.[75] This process and the outcomes are discussed in Section III.C.4 below.

Many states allow parents to retain the right to consent but do not provide details of how consent needs to be obtained and do not place specific requirements on the state to get the consent. Even in states where the parent retains the right to consent to psychotropic medications, the ultimate authority rests with a judge because there is a process for the agency to challenge or override the parent's consent when the prescribing physician believes that is necessary, as discussed in Section III.C.4 below. For example, West Virginia grants authority to parents to consent to psychotropic medication for youth in foster care; however, if consent is not given or is revoked

[72] Arizona Department of Health Services *Practice Protocol: Informed Consent for Psychotropic Medication Treatment*, last revised 11/20/2007, available at http://www.azdhs.gov/bhs/guidance/psyc.pdf.
[73] Fla. Admin. Code R. 65C-35.007 (2010).
[74] Fla. R. Juv. P. 8.355 (2010), *Administration of Psychotropic Medication to a Child in Shelter Care or in Foster Care When Parental Consent Has Not Been Obtained*.
[75] Fla. Stat. § 39.407 (2010).

and the physician disagrees, the agency can petition the court to order the medications (and thereby override the parent's decision).[76]

Another way that states maintain parents' rights to consent to psychotropic medication is by classifying psychotropic medication as something other than ordinary medical care, such that parental permission is required in advance. So, for example, in Massachusetts, when a child enters foster care, the state agency has the authority to consent to routine medical treatment,[77] but extraordinary medical treatment, which includes antipsychotic drugs, requires parental consent (or judicial consent after termination of parental rights).[78] In 2009, Oklahoma amended its statute on medical care and treatment to classify "the provision of psychotropic medications" as "routine and ordinary medical care."[79] Parental consent is required for "extraordinary medical care and treatment" of children in foster care, but since the 2009 change, consent for psychotropic medications now falls within the purview of the agency. Even when parental consent was needed for psychotropic medication, though, the agency was only required to make "reasonable attempts" to secure consent, and trying to contact the parents by phone qualified as a reasonable attempt.[80]

The District of Columbia Court of Appeals recently held that under the D.C. Code, the administration of psychotropic medication is not "ordinary medical care."[81] In *In re G.K.*, the Court found that decision-making relating to psychotropic medications is a residual parental right and not one that is transferred with "legal custody" along with the responsibility to provide "ordinary medical care" to the child.[82] So, when custody was given to the agency, the parent retained the right to consent to psychotropic medication and only the court had authority to either appoint someone with the power to consent to psychotropic medication or to override the parents' decision by finding by clear and convincing evidence that the parents' decision was not in the best interests of the child.[83]

As *In re G.K.* shows, when parents retain the right to consent, states must identify someone who can consent in circumstances when parents cannot or will not participate in the consent process. Some states designate the agency and some require the court to step in in place of the parent. Other states require the appointment of a person who has specific authority to consent to psychiatric treatment.

2. Consent by youth

Even though the child may not be able to legally consent to medications, the child is ultimately the one who has to comply with a medication regime—willingly or by force. A few states require

[76] W. Va. Code R. § 78-2-9 *et seq.* (2010).
[77] 110 Code Mass. Rules § 11.04 (2010).
[78] 110 Code Mass. Rules § 11.01 *et seq.* (2010).
[79] Okla. Stat. tit. 10A § 1-3-102 (2010).
[80] Okla. Admin. Code § 340:75-13-65(h) (2010).
[81] *In re G.K.*, 993 A.2d 558 (D.C., 2010).
[82] *Id.* at 566.
[83] *Id*. at 570.

the assent of the youth to the prescriptions, but that assent can easily be overridden.[84] Florida defines "assent" as:

> …a process by which a provider of medical services helps the patient achieve a developmentally appropriate awareness of the nature of his or her condition; informs the patient of what can be expected with tests and treatment; makes a clinical assessment of the patient's understanding of the situation and the factors influencing how he or she is responding; and solicits an expression of the patient's willingness to accept the proposed care.[85]

In Texas, youth age 16 and older can consent to their own medical treatment. Youth of that age in foster care, who are not at an inpatient mental health facility, retain the right to consent to or deny treatment, with restrictions.[86] Agency caseworkers must inform a teen of this right before he turns 16. If the teen then wants to make her own medical decisions, she must petition a judge and the judge holds a hearing to decide what, if any, decisions the young person can make. However, even when a teen can make his own decisions, if the agency disagrees with his decision, the agency can request another hearing before the judge. The agency's motion must include specific information and the teen must have an attorney ad litem. The court will override the teen's decision only if it finds, by clear and convincing evidence

> that the medical care is in the best interest of the foster child and:
> (1) the foster child lacks the capacity to make a decision regarding the medical care;
> (2) the failure to provide the medical care will result in an observable and material impairment to the growth, development, or functioning of the foster child; or
> (3) the foster child is at risk of suffering substantial bodily harm or of inflicting substantial bodily harm to others.[87]

Many states treat mental health care differently than other kinds of health care, allowing children who cannot consent to general health care to obtain mental health treatment without parental consent and often without parental notification. For example, California and Illinois set the age for consent for mental health treatment at 12, Washington sets the age at 13, Pennsylvania and Oregon set the age at 14, and New York sets the age at 16.[88] States that allow minors to consent to mental health care have exceptions and caveats regarding parental notification and may or

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[84] *E.g.*, Connecticut Department of Children and Families Psychotropic Medication Advisory Committee *Guidelines for Psychotropic Medication Use in Children and Adolescents*, Jan. 2010, http://www.ct.gov/dcf/lib/dcf/behavorial_health_medicine/pdf/guidelines_psychotropic_medication.pdf, chapter 2 ("In addition to informed consent by the DCF Centralized Medication Consent Unit and/or DCF Regional Medical Director and *assent by patients over the age of 8*, psychotropic medications must be prescribed in collaboration with other treatment providers and with the primary care physician.") (emphasis added).

[85] Fla. Admin. Code R. 65C-35.001(1) (2010).

[86] Tex. Fam. Code § 266.010 (2010).

[87] Tex. Fam. Code § 266.010(g) (2010).

[88] Cal. Fam. Code § 6924(b) (2010), 410 Ill. Comp. Stat. § 210/4 (2010), Wash. Rev. Code § 71.34.530 (2010), Pa. Cons. Stat. § 7201 (2010), Ore. Rev. Stat. § 109.675 (2010), N.Y. Men. Hyg. § 33.21 (2010).

may not allow psychotropic medications without parental consent. For example, while youth age 12 and older in California can receive mental health treatment or counseling without parental notification, parental consent (or judicial consent) is needed for psychotropic medications until age 18.[89] In New York and Connecticut, however, at age 16 a youth can consent to mental health care that includes psychotropic medication.[90] A few states, including Colorado, Georgia, and Tennessee, appear to have no minimum age at which a minor can consent to treatment for substance abuse.[91] In general, age provisions governing consent to medical care and mental health care apply whether youth are in parental custody or state custody. Texas illustrates an exception: a 16- or 17-year-old who is in foster care and wants to consent to her own medical care has to request a judicial hearing at which the judge will determine the teen's capacity to consent to medical care.[92]

As with parental consent, when youth have authority to consent to their own medical care, a process exists for the agency to challenge the youth's decision. The process usually includes the agency requesting that the court authorize medication over the youth's objection. States' processes for this sometimes list the required court findings and the standard of evidence that must be met.

Even in states where the child does not have authority to consent to mental health treatment, agencies may be required to include youth in the decision-making process around psychotropic medications and may specify the ways in which the child must be involved and what must happen if the child does not consent to psychotropic medication.[93] These requirements may be related to the age of the young person. In Connecticut, youth age 14 and older must provide written consent to take psychotropic medications and can refuse to consent to them.[94] If the youth refuses and the DCF physician believes the medication is needed, DCF policy establishes a detailed process involving several physicians and a psychiatrist to decide whether DCF should ask the court to order the medication against the child's will.[95] States that allow youth who are in their parents' custody to make their own decisions regarding mental health care generally apply that same principle to youth in foster care, but add procedures to address disagreements between the agency, physician and youth.

3. Consent by agency

In most states, when a child is brought into foster care, the agency that has legal custody of the child has authority to consent to most medical treatment, including the administration of psychotropic medications. In recent years, however, some states have added specific provisions about consent for psychotropic medication. In states where the agency has authority to consent to

[89] Cal. Fam. Code § 6924(f) (2010).
[90] N.Y. Men. Hyg. § 33.21 (2010) and see Conn. Gen. Stat. § 17a-495, § 17a-540, § 17a-543 (2010).
[91] Colo. Rev. Stat. § 13-22-102 (2010), Ga. Code § 37-7-8 (2010), Tenn. Code § 63-6-220 (2010).
[92] Tex. Fam. Code § 266.010 (2010).
[93] *See, e.g.,* Fla. Admin. Code R. 65C-35.005 (2010), *Child Involvement in Treatment Planning*, and Connecticut Department of Children and Families *Guidelines for Psychotropic Medication Use in Children and Adolescents* (January 2010), and Ill. Admin. Code tit. 89 § 325.40(b) (2010).
[94] Conn. Department of Children and Families Policy 44-5-2.2 (effective date May 5, 2010).
[95] *Id.*

psychotropic medication, the authority often rests with a specific individual, who may be the case manager, the Commissioner or Director or that person's designee, or a specialized unit within the agency. There are also states in which "the agency" has the authorization and no specificity is provided regarding who can consent for the agency-- the agency can decide to whom the authority is delegated.

Some states are clear that consent rests with the agency having legal custody of the child, but are laissez faire when it comes to identifying the specific person who can grant consent. For example, in Arizona, "[t]he foster parent, group home staff, foster home staff, relative or other person or agency in whose care the child is currently placed…" may consent to mental health treatment including psychotropic medications.[96] Another example is Georgia, where "a custodian to whom legal custody has been given by the court" has authority over ordinary medical care.[97] When a child is placed in state custody in Georgia, the legal custodian is the agency, without specific reference to a person or unit within the agency. The agency policy governing the health needs of youth in foster care does not provide any additional specificity and seems to indicate that decision-making authority rests with individual case managers.[98] Oklahoma provides yet another example—the statutes grant authority over ordinary medical care to the agency and "psychotropic medications" are included in the definition of ordinary medical care. However, Oklahoma statutes and regulations do not specify who can consent on behalf of the agency. In fact, the administrative code states that the agency may authorize "any person, foster parent, or administrator of a facility…to consent… upon the advice of a licensed physician."[99]

Texas and Illinois provide examples of a specific person within the agency being given authority to consent to medical care. The practice of identifying a specific person is quite different from the default position of most states that grants authority to the individual case manager. Texas requires the agency, the entity with the legal authority to consent, to pick one person to be child's "medical consenter."[100] The consenter can be a caregiver, caseworker, or other person allowed by statute and cannot be an employee of a staffed facility. Everyone involved (judge, parents, child, other parties) has to be told who the consenter is. The medical consenter has to be specially trained on the informed consent process and must participate in each medical appointment. The court can authorize an individual outside the agency as the medical consenter (such as allowing the parent to continue making the decisions or giving this authority to a foster parent). If that happens, the consenter is responsible to the court and not to the agency, but must communicate decisions to the agency.

Illinois' version of identifying a specific person within the agency is a hybrid of the single person and the specialized unit within the agency. Illinois grants authority over medical decisions for youth in foster care to either the "Guardianship Administrator," who is the person designated by the agency to "serve as guardian or custodian of children,"[101] or to a specially trained "authorized

[96] Ariz. Rev. Stat. § 8-514.05(C) (2010).
[97] Ga. Code § 15-11-13 (2010).
[98] Georgia DHS Social Services Manual, Chapter 1000, Section 1011.2 (2010).
[99] Okla. Admin. Code 340:75-13-65(e) (2010); *see also* Okla. Stat. tit. 10A § 1-3-102 (2010).
[100] Tex. Fam. Code § 266.004 (2010).
[101] Ill. Admin. Code tit. 89, pt. 327.2 (2010).

agent," who is authorized to act in place of the Guardianship Administrator to provide consent in medical and other matters.[102] The authorized agent is an identified person, not the case manager, who has special training regarding psychotropic medications and is a member of the agency's "consent unit."[103] The authorized agent is the person vested with actual authority to consent, but in practice works as part of an expert team to make the decision. The agency in Illinois collaborates with the University of Illinois to obtain expert advice on every prescription for psychotropic medication for youth in foster care. The process requires all requests for psychotropic medication to be sent to the agency consent unit. Once that unit verifies that all the information that is needed has been collected, the request is sent to the University of Illinois Consultation Team headed by a board certified Child and Adolescent Psychiatrist. The consultation team makes a recommendation to the authorized agent, who then provides or denies consent for the medication, based on the recommendation of the consultation team.[104]

Tennessee has a model that is similar to the Illinois model, but this model only comes into play for youth younger than age 16 whose parental rights have been terminated or whose parents are unwilling or unable to consent,[105] because youth age 16 and older have the right to consent to their own treatment.[106] For youth younger than 16, Tennessee gives consent authority for medical care to nurses staffing the regional health units for the 12 regions of the state.[107] Tennessee's nurses serve in a role similar to that of the Illinois authorized agents. Requests for psychotropic medication are sent to the Regional Health Unit nurse, who enters information into the statewide database, communicates with the central office nurse practitioner and child psychiatrist, and signs the actual consent forms. A psychologist is located in each of the regional health units along with the nurse, and the agency's state office employs a medical director, a pediatric nurse practitioner and a consulting child psychiatrist. Certain requests for prescriptions are required to be approved by the psychiatrist, such as psychotropic medications for a child younger than five, and certain requests must be reviewed by the central office nurse practitioner and possibly a psychologist or psychiatrist, such as psychotropic medications for children age five to ten.[108] In addition to the central office experts, Tennessee has three Centers of Excellence for Children in Custody that provide individual case consultation and a variety of other services for children in state custody.[109]

Connecticut grants authority over medical decisions to the agency head, but like Tennessee and Illinois, has a Centralized Medication Consent Unit (CMCU) staffed by psychiatric mental health

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[102] Ill. Admin. Code tit. 89, pt. 325.20 (2010).
[103] "Centralized Psychotropic Consent Procedure, http://www.psych.uic.edu/csp/Centralized%20Psychotropic%20Consent%20Procedure.pdf, accessed 11/8/10.
[104] *See, e.g., Id.* and Ill. Admin. Code tit. 89, pt. 325.10 *et. seq.* (2010).
[105] Tenn. Dept. of Children's Services Admin. Policies & Procedures: 20.18(D) & 20.24(B) (2010).
[106] Tenn. Code § 33-8-202 (2010).
[107] *Prescription Psychotropic Drug Use Among Children in Foster Care, Hearing before the Subcommittee on Income Security and Family Support of the House Committee on Ways and Means,* 110th Congress (May 8, 2008), written testimony of Tricia Lea, Ph.D.
[108] Michael W. Naylor, et al., *supra* note 8 at 175.
[109] East Tennessee State University: http://www.etsu.edu/coe/excellence/statecustody/index.htm, University of Tennessee Memphis: http://www.uthsc.edu/bcdd/services/programs/state_custody.php, and Vanderbilt University: http://www.mc.vanderbilt.edu/coe/.

nurses to deal with psychotropic medication.[110] Requests for psychotropic medication are sent to the CMCU where the nurses can, depending on such factors as the type of medication, the age of the child, and the child's particular situation, provide consent or consult the Regional Medical Director, who is a board certified child and adolescent psychiatrist. The agency has three Regional Medical Directors. The decision of the Regional Medical Director is final, unless there is strong disagreement, in which case the provider can appeal to the agency medical director. In Connecticut, the decision of the agency's medical director is a final decision.[111] In most other states that address the issue of consent, the final decision about whether to administer medications rests with the judge.

4. Consent by judge

Several states involve judges in one or more aspects of the consent process. The role of the court falls into two broad categories. The first is when there is disagreement among two or more of the following: a person with authority to consent to medication, the prescribing provider, the agency, and the youth. In states that have defined the consent process, when disagreements arise, they are resolved through a court hearing, with the exception of states like Connecticut, where final authority rests within the agency.

In general, in states where parents retain the right to consent, when there is disagreement with the parents' decision, the agency or physician can petition the court for a hearing which could result in the court ordering or discontinuing medication over the parents' objections.[112] Similarly, for older youth who have authority to consent to their own medical care, the court is a forum in which physicians and agencies can challenge the youth's decision.[113]

In Florida, if the agency disagrees with the parents' decision, the agency makes a motion asking the court to authorize the medication. The motion must be accompanied by a report containing detailed information about the child, the medication, and the prescribing physician. A court hearing is only held if a party files an objection to the motion within two working days after being notified of the motion.[114]

Several states specify the findings the court must make before overriding the parents' decision. In addition, the information the agency must provide to the court is specified in statute or rule and is extensive.[115] The burden of proof for these hearings may also be set out in statutes or case law. For example, Florida has a preponderance of the evidence standard and the District of Columbia requires clear and convincing evidence.[116]

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[110] Connecticut Department of Children and Families Policy 44-5-2.1.
[111] Connecticut Department of Children and Families *Guidelines for Psychotropic Medication Use in Children and Adolescents*, January 2010, chapter three.
[112] *E.g.* Fla. Stat. § 39.407 (2010) and W. Va. Code R. § 78-2-9.4.e (2010).
[113] *E.g.* W. Va. Code R. § 78-2-9.4.e (2010), Tex. Fam. Code § 266.010 (2010), 55 Pa. Cons. Stat. § 3130.91 (2010).
[114] Fla. Stat. § 39.407 (2010).
[115] *E.g.*, Fla. Stat. § 39.407(c) (2010).
[116] *E.g.*, Fla. Stat. § 39.407(d)(2) (2010), *In re G.K.*, 993 A.2d 558 (D.C., 2010).

In a few states, the court is the entity with authority to consent. In California, consent rests with the judge, and only with the judge, for all youth in foster care.[117] The judge may, however, delegate the authority back to the parents when that decision will not pose a danger to the youth. When a child in foster care in California is prescribed a psychotropic medication, the agency must request court authorization and within seven days of receiving the request, the court must approve or deny the request, or set a hearing date.[118] The specific process for obtaining judicial consent is detailed in the California Rules of Court and many counties also have a local court rule addressing the issue.[119]

In most other states, such as Florida and Tennessee, the court only has consent authority when the parents cannot give consent—such as after termination of parental rights. If the birth parents cannot give consent, rather than allowing the agency to step in the place of the parents, the court does so.[120]

In Texas, the judge has wide authority regarding medical care for a youth in foster care; a judge can issue any order related to medical care that the judge determines is in the best interest of the child (sua sponte or in response to a request from a party or physician).[121] The court decides whether a 16- or 17-year-old can make his own medical decisions. If the agency or physician later disagrees with the youth's decision, the judge can be asked to decide whether the youth's decision should be overridden by the judge.[122] Texas also allows a parent, child's attorney, guardian ad litem, or foster parent to petition the court for medical care that person believes to be in the child's best interest.[123] In addition, a physician who has concerns about medical care being provided to a youth in foster care can file a letter with the court.[124]

D. Oversight

An oversight process is the mechanism by which states ensure that children in foster care receive the medications they need in a timely fashion, and only those medications that are clinically indicated and appropriate for the child's diagnosis, age, and lifestyle. In some states, like Connecticut, Illinois, and Tennessee, the oversight process is embedded in the consent process and in other states the oversight process is distinct from the consent process.

In this paper, oversight is used broadly to refer to any mechanisms that improve the process of addressing the mental health needs of youth in foster care. Oversight is not used to imply an ombudsman-type program or formal systems that operate as checks and balances. The Rutgers

[117] Cal. Wel. & Inst. Code § 369.5(a) (2010).
[118] Cal. Wel. & Inst. Code § 369.5(b), (c) (2010) and Cal. Wel. & Inst. Code § 739.5 (2010).
[119] Cal. Rules of Ct. Juv. R. 5.640 (2010).
[120] *See e.g.*, Fla. Stat. § 39.407 (3)(a) (2010).
[121] Tex. Fam. Code § 266.004(g) (2010).
[122] Tex. Fam. Code § 266.010 (2010).
[123] Tex. Fam. Code § 266.004(e) (2010).
[124] Tex. Fam. Code § 266.004(f) (2010).

study described in section II.B.2 refers to the examples provided in this section as "innovative ways to improve prescribing practices."[125]

1. Oversight over individual prescriptions

Oversight over individual prescriptions involves examining an individual child's medication regime. This can happen at the time a prescription is issued or at specific checkpoints in the system. Illinois provides oversight at the individual prescription level-- every prescription for a psychotropic medication is reviewed by a psychiatrist who examines the child's full medical record and the notes of the prescribing provider before advising the authorized agent about whether to consent to the medication.[126] In California, Texas, and Florida, one checkpoint for individual case reviews is each dependency case proceeding-- the judge must review the medical care for the child, including the prescriptions the child is taking, the reasons for the prescriptions, and the extent to which the medications are achieving their purposes.[127]

Tennessee and Connecticut use a database to track the medications of youth in foster care. When a prescription falls outside the psychotropic medication utilization parameters, automatic alerts are sent to the agency medical directors. In addition to using the database, Tennessee and Connecticut have specialized consent units within the agency and conduct individual case reviews for each prescription that meets certain criteria. A database to track the use of psychotropic medications can be built as a stand-alone system or can be incorporated into a state's version of SACWIS.

Texas provides individual review of certain prescriptions through its innovative Medicaid managed care organization (MCO). Star Health is the MCO specifically designed to coordinate the medical care of youth in foster care. The system was developed as a result of 2005 legislation requiring the Health and Human Services Commission to develop a statewide healthcare delivery model for youth in state custody.[128] The system includes a "health passport" for each child so that everyone involved with the child can have access to current and accurate health information. The Star Health system contains real time prescription data so when a prescription is issued that falls outside the utilization parameters, the Star Health medical director or a qualified child psychiatrist reviews the child's situation.

Several states maintain oversight over individual prescriptions through their Medicaid provider systems. The child welfare agency partners with the state agency that manages the Medicaid program. Prescriptions that are outside established guidelines trigger some kind of response when they are entered into the Medicaid system for payment. In Florida, for example, prior approval is required for an antipsychotic medication prescription for a child under the age of

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[125] *See Antipsychotic Medication Use in Medicaid Children and Adolescents: Report and Resource Guide from a 16-State Study*, *supra* note 18.
[126] *See* Ill. Admin. Code tit. 89, pt. 325.10 *et. seq.* (2010) and http://www.psych.uic.edu/csp/physicians/faq_c.html (consent process for DCFS wards).
[127] *E.g.* Tex. Fam. Code §266.007 (2010) (requires DFPS to include a summary of medical care in court reports that DFPS submits for hearings required under Tex. Fam. Code §263 or more frequently if ordered by the court).
[128] Tex. Fam. Code §266.003 (2010).

six.[129] The prescription is not approved for Medicaid reimbursement until a second medical review is conducted. The review is to be performed within 24 hours of receipt of a completed request packet. This level of oversight was made possible in 2005 when the Agency for Health Care Administration implemented the Florida Medicaid Drug Therapy Management Program for Behavioral Health.[130] Within eight months of starting the preapproval process, the number of Medicaid claims for antipsychotic meds for young children declined, greater consistency was achieved with the published guidelines for prescribing antipsychotic medications, and the proposed doses of antipsychotic medications decreased.[131] The second opinion case reviews are conducted by the Department of Psychiatry of the University of Florida College of Medicine through a contract with the Florida child welfare agency.

Another example of using pre-authorization requirements to institute controls on the prescription of psychotropic medications through Medicaid rules can be found in Hawaii. The law, which is effective until June 30, 2012, says that "an individual must have two failed attempts on a generic antidepressant medication to receive coverage for a new brand-name antidepressant prescription."[132] A similar rule exists in Washington, which mandates a second opinion by a community psychiatrist for all ADHD medication prescriptions that fall outside specified safety thresholds (such as being prescribed for children under age 5).[133] In addition, in 2009, Washington enacted SB5892, authorizing five tools for Medicaid to use to better control pharmacy costs and improve quality, one of which is "[a]uthorizing a generic first program for all new starts…."[134] Name brands can be prescribed with a peer-to-peer second opinion or when certain criteria are met.

Less extensive Medicaid review processes include Pennsylvania's use of the Bureau of Data and Claims Management to monitor the use of psychotropic medications for youth in foster care and North Carolina's requirement that a pharmacist or physician review the psychotropic medication prescriptions for children on Medicaid at least every six months.[135]

2. Systemic oversight

Systemic oversight looks at prescribing practices, safety, and efficacy at the system level rather than at the individual level, mainly through tracking and reporting. States can monitor prescription practices over time for children in foster care and look for such things as which providers vary the most from mandatory or recommended guidelines, whether there is a nexus between medications prescribed and free samples or other incentives from pharmaceutical representatives, and whether the use of psychotropic medications is higher at particular facilities or for particular subgroups in foster care.

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[129] *Oversight of Off-Label Prescribing of Atypical Anti-Psychotic Medications for Children Under Six Years of Age Covered by the Florida Medicaid Program, supra* note 56.
[130] Fla. Stat. § 409.912(39)(a)10 (2010).
[131] *Oversight of Off-Label Prescribing of Atypical Anti-Psychotic Medications for Children Under Six Years of Age Covered by the Florida Medicaid Program*, supra note 56 at 3.
[132] Hawaii Rev. Stat. § 346-59.9 (2010) (with exceptions including appropriate prior authorization).
[133] *E.g.*, Washington State Department of Social Services *2007 Fact Sheet: ADHD Drug Utilization Review Program*, http://hrsa.dshs.wa.gov/news/Fact/FS007024ADHDutilizationrules.pdf.
[134] *State Practices: 36 State Practices to Improve AP Medication Safety and Quality, supra* note 20 at 8.
[135] Michael W. Naylor, et al., *supra* note 8 at 185.

State agencies should compile regular reports detailing how many youth in foster care are taking what kinds of psychotropic medications for what reasons and at what ages. Reports should track what additional or alternative supports or therapies are provided along with or instead of psychotropic medication as well as what level of medication monitoring and management is provided to each child. Reports should be presented in ways that can be made public and preserve the confidentiality of children in the system. States can require that their SACWIS systems include the ability to track this type of information. For example, the Tennessee Kids Information Data System (TNKIDS) contains a medications database the agency uses to track psychotropic medications. Certain entries (such as medications falling outside accepted parameters) trigger an email alert to the Chief Medical Officer for the agency.[136]

Some states use automated tracking systems that are separate from the SACWIS system and were designed specifically to monitor psychotropic medication. Sometimes states work with other state agencies that manage Medicaid programs to share data and enhance the accuracy of information collected. While not specific to foster care, in 2005 the New York State Office of Mental Health implemented Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES), an electronic business intelligence system designed optimize clinical decision-making and provide detailed information to physicians and medical executives.[137] The system has been successfully implemented statewide, has won several awards, and has led to improved prescribing practices. This is but one example of a specialized automated system to improve management of diseases and treatment modalities; there is a wide array of models for Georgia to learn from.

One reason states are interested in systemic oversight is the likelihood of associated cost savings. Psychotropic medications are expensive and it is helpful for states to know what they are paying for. When Texas examined psychotropic medications for youth in foster care, the Comptroller learned that in FY2004, 16 psychotropic medications cost the state $28.7 billion, which comprised over 73% of the Medicaid expenditures on psychotropic medications for that year.[138] If less costly or fewer medications are as safe and effective as name brand medications and combinations of several medications, states should encourage the cost-saving treatments. The New York PSYCHKES, described above, is expected to result in over $25 million in savings during the second year of its statewide rollout.[139]

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[136] *Prescription Psychotropic Drug Use Among Children in Foster Care, Hearing before the Subcommittee on Income Security and Family Support of the House Committee on Ways and Means*, 110th Congress (May 8, 2008), written testimony of Tricia Lea, Ph.D.

[137] http://www.omh.state.ny.us/omhweb/psyckes/information.html, accessed 11/9/2010. For more information see http://www.tomwhitemd.com/psyckes and https://psyckesmedicaid.omh.state.ny.us/Common/Faq.aspx, accessed 11/9/2010.

[138] Julie Zito and Daniel Safer, *External Review: A Pharmacoepidemiologic Analysis of Texas Foster Care*, 2006, Page ER-18.

[139] http://www.tomwhitemd.com/psyckes, accessed 11/8/2010.

3. Oversight from external experts and education of providers

There are many ways to involve experts, who are independent from the child welfare and Medicaid systems, in monitoring and improving the administration of psychotropic medications to youth in foster care. Most of these approaches are voluntary, non-adversarial, and have been successfully used by physicians and systems providing medical services other than psychiatric treatment.

The Rutgers report discussed in section II.B.2. above describes many state practices that involve diplomatically providing expert advice and information to prescribing physicians. The Massachusetts Child Psychiatry Access Project and Maine's Academic Detailing Project are described in that section. California is developing a Pharmacy Tool Kit for use in county mental health services offices.[140] The tool kit includes information on quality improvement concepts and methods; reference materials including sample forms, reports, and clinical guides; and a set of established quality measures. The Rutgers report includes detailed descriptions and contact information for a variety of programs that states can consider implementing.

Several states have created web sites where prescribers, agency personnel, foster parents, and others can obtain current, accurate information about mental health care and psychotropic medication. The *AACAP Position Statement on Oversight of Psychotropic Medication Use for Children in State Custody: A Best Principles Guideline* includes this type of website as an ideal standard for states to meet.[141] The Florida Medicaid Drug Therapy Management Program for Behavioral Health is one example of a web site that provides information, including the state's recommended guidelines for medications.[142] As in several other states, the organization providing this web site also provides services such as continuing medical education for physicians who prescribe psychotherapeutic drugs to children, dissemination of best practices information to pediatricians and other primary care physicians, and providing tools to promote safe prescribing practices.

In Connecticut, a statute was passed in 2006 requiring the Commissioner of Mental Health and Addiction Services to create a web site "to provide timely access to mental health care information and assistance for children, adolescents and adults."[143]

In Florida, the Department of Psychiatry at the University of Florida hosts a "MedConsult" Line that allows doctors to obtain medical consultation and allows parents, foster parents, case managers, guardians ad litem, and courts to receive information on psychotropic medication, particularly in relation to the informed consent process.[144] Washington also has a child mental health phone consultation system that connects primary care providers with social workers, child psychologists and child psychiatrists affiliated with Seattle Children's Hospital. Providers who call can obtain information about mental health concerns, phone consultation on cases,

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[140] *State Practices: 36 State Practices to Improve AP Medication Safety and Quality*, *supra* note 20 at 45.
[141] http://www.jdcap.org/SiteCollectionDocuments/Foster%20Parents%20Best%20Principle.pdf.
[142] http://flmedicaidbh.fmhi.usf.edu/.
[143] Conn. Gen. Stat. § 17a-453e (2010).
[144] *See, e.g.*,
http://www.dcf.state.fl.us/initiatives/GMWorkgroup/docs/meeting070609/July6presentationStreit.pdf.

educational tools and reviews of client records. The program is funded by the state legislature and is not statewide.[145]

The University of Illinois at Chicago Consultation team that provides independent review of prescriptions also provides training, creates or consults on educational materials, consults on particularly difficult cases, and provides other services to the agency related to the mental health needs of youth in foster care.[146] Illinois also has a "Pharmacy and Therapeutic Manual," that guides practice and decision-making about consent.

IV. Recommendations for Georgia

Prescribing psychotropic medications to youth in foster care raises many concerns. Georgia is in a position to address those concerns by developing processes and practices that keep young people safe and help them maximize their mental health outcomes. This paper describes expert recommendations and studied practices that have improved other states' mental health treatment for youth in foster care. Georgia currently has little in place to address the specific needs of youth in foster care who are receiving psychotropic medications. This void presents a remarkable opportunity for Georgia to design a system that improves outcomes for abused and neglected children and can result in significant cost-savings. The list below describes the actions that are most critical for Georgia to take and includes specific suggestions for the Committee on Justice for Children.

1. Collect and disseminate accurate information

Policy makers, state agencies, and taxpayers need to know that the health of youth in state custody is being protected. Georgia needs to obtain accurate information about psychotropic medications and youth in foster care, including how many youth of what ages are receiving which medications for what purposes and at what costs. It would be helpful to know the level of clinical oversight being provided to children on psychotropic medications and to be able to make comparisons among children in foster care and children who are insured through Medicaid for other reasons. The information could likely be obtained through an audit conducted by a state agency such as the Office of Planning and Budget or the Georgia Department of Audits and Accounts or through quality assurance mechanisms within the Department of Community Health. Having accurate information will help Georgia appropriately address concerns about psychotropic medications.

2. Develop guidelines for the administration of psychotropic medication

Physicians, caregivers, and advocates for children need to know what medication regimes are appropriate for youth. Georgia needs to develop guidelines for the use of psychotropic medications for youth in foster care. Several national models exist which can easily be adapted for Georgia. Psychotropic medication utilization parameters should be developed by experts in child psychiatry along with key system stakeholders and agency leaders. The parameters must be

[145] www.palforkids.com, accessed 11/9/2010.
[146] http://www.psych.uic.edu/csp/home/purpose.html, accessed 11/8/2010.

based on current peer-reviewed research, best practices in the field of child psychiatry, and must be consistent with parameters and guidelines recommended by local and national experts in the fields of child psychiatry and pharmacology. Once developed, the practice parameters need to be widely circulated among all possible prescribers and those working with youth in foster care.

3. Develop a clear consent process

Everyone working with youth in foster care should know exactly who has authority to consent to psychotropic medications for the youth and how that consent is to be obtained. Georgia needs to develop a clear process for obtaining informed consent for the administration of psychotropic medications to youth in foster care. The process needs to be specific about who has authority to consent for a youth in foster care. The Department of Human Services has legal custody of the youth, but a specific individual, inside the agency or outside, needs to be identified as the person who is responsible for agreeing to medications for a particular child. Given Georgia's current silence on this issue, it is critical that all parties understand who can consent for the youth and what steps have to occur to obtain consent. An appropriate consent process addresses how the birth parents or guardian and young person will be involved. The consent process must also provide an avenue for resolving differences of opinion about whether a child should receive medications—who should have the ultimate authority to decide?

4. Engage experts and obtain independent reviews

Youth in foster care should have access to the best psychiatric care obtainable in Georgia. Expert, board-certified child psychiatrists should be available to respond to provider questions, provide phone consultations, and conduct an independent review of all psychotropic medications prescribed for youth in foster care. Case managers, mental health treatment providers, foster parents, birth parents, judges, lawyers, and anyone else working with youth in foster care should have access to high quality information and training about the mental health needs of youth in foster care. Georgia should develop one or more independent clinical teams that include a board-certified child psychiatrist to provide the following services:

- individual case consultation to the state agency and prescribers;
- training for those who work with youth in foster care;
- independent review of all prescriptions for psychotropic medications that are written for youth in foster care before the prescription can be filled.

Georgia will need to develop a process for the independent review of prescriptions. Georgia should consider replicating the Illinois model in which the University of Illinois College of Medicine Department of Psychiatry contracts with the Department of Children and Family Services to ensure the safety and appropriateness of the prescriptions being provided to youth in foster care.[147]

5. Provide comprehensive, individualized mental health treatment

Youth in foster care should have a comprehensive mental health treatment plan that includes consideration of a variety of interventions and treatments that may include medications. The treatment plan needs to be developed after a comprehensive mental and physical health

[147] *See* http://www.psych.uic.edu/csp/home/mission.html, accessed 11/8/2010.

evaluation and should be tailored to the youth's age, abilities, symptoms, and diagnoses. An advocate for the child who may be the child's foster parent, relative, attorney, or guardian ad litem should participate in developing the plan. The plan should have a consistent manager and should be reviewed at least annually. For youth receiving psychotropic medications, an independent clinical team should conduct a semi-annual review of each child's medications and mental or behavioral health services, treatments, and therapies. The independent clinical review team must include a child psychiatrist and cannot include the prescriber or an employee or contractor of the child caring institution or residential treatment facility where the child is housed.

6. Create quality assurance mechanisms

Youth in foster care are growing and changing, research is evolving, and the systems that serve youth need to adapt to new information and circumstances. Georgia needs to establish mechanisms to continuously improve all systems serving the mental health needs of youth in foster care and to hold all parts of the systems accountable. Georgia should develop quality assurance practices that include, but are not limited to the following:

- Disseminating periodic public reports about the use of psychotropic medication for youth in Georgia's foster care system.
- A process for reporting and tracking mental health services for individual youth, including detailed prescription information.
- Inclusion of health care information in periodic judicial reviews of a child's case.
- A process for requesting a court hearing to discuss the child's mental health treatment plan when a party has serious, legitimate concerns about it.
- Involvement of the child's attorney in decision-making about mental health care. If a child who is taking psychotropic medication does not have an attorney, one should be appointed for the child.
- Mandated training on psychotropic medications and the mental health needs of youth in foster care for all agency personnel, private providers, and caregivers who work directly with youth in foster care.

7. Raise awareness about psychotropic drugs and youth in foster care

The Committee on Justice for Children can take several steps to improve decision-making about the mental health care of youth in foster care:

(a) Implement the AACAP recommendation to

> create a website to provide ready access for clinicians, foster parents, and other caregivers to pertinent policies and procedures governing psychotropic medication management, psychoeducational materials about psychotropic medications, consent forms, adverse effect rating forms, reports on prescription patterns for psychotropic medications, and links to helpful, accurate, and ethical websites about child and adolescent psychiatric diagnoses and psychotropic medications.[148]

[148] 2005 *AACAP Position Statement on Oversight of Psychotropic Medication Use for Children in State Custody*, *supra* note 52.

Much of the information that has already been developed on this topic is available for dissemination and posting on web sites as long as credit is provided to the authors. Many states have their consent forms, consent processes, utilization parameters, agency rules, and other materials posted on web sites and available for use by other states.

(b) Provide specialized training to judges, attorneys, agency personnel, and service providers about this issue.
(c) Assist with the dissemination of Guidelines for the administration of psychotropic medication after they are developed by ensuring that every juvenile court judge has a copy of the Guidelines.
(d) Consider whether any court rules on this topic would be helpful.
(e) Encourage judges to review the child's medical and mental health care at every review of a deprived child's case and consider whether this should be required by legislation.
(f) Continue to support the work of the Cold Case Project.

V. Conclusion

Who decides whether a child in foster care should take psychotropic drugs? Who *should* decide? Leading national organizations and many states have strongly replied that experts with specialized knowledge must make decisions about medications for youth. They have shown that oversight systems protect the health of youth in foster care and ensure consistency and excellence in mental health care for these youth.

Until now, Georgia has allowed individual case managers and providers who can write prescriptions to decide whether a child in foster care should take psychotropic medications. Georgia has not really examined how this practice has affected children. Now that Georgia has begun to ask who should decide which of the 7500 children in foster care receive psychotropic medications and why, Georgia should answer the question by creating a psychotropic medication oversight system using independent child psychiatry experts to improve the health of youth in foster care.

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