Disability Rights Oregon

TO: Chair Williams, Vice-Chair Leif, Vice-Chair Ruiz, & Members of the House Committee on Human Services
FROM: Disability Rights Oregon (DRO)
DATE: February 26, 2021
RE: DRO 's Testimony in Support of House Bill 2333

Dear Chair, Vice-Chairs, and Members of the Committee:

Disability Rights Oregon submits this testimony in support of House Bill 2333 requiring the Department of Human Services (DHS) to report information regarding prescription of psychotropic medications to youth in foster care.

DHS is required to provide appropriate mental health treatment to foster youth in its care including appropriate use of psychotropic medication (i.e., medication used to treat clinical symptoms or health conditions such as depression, bipolar disorder, and schizophrenia). For youth with mental health needs, psychotropic medications may be the most effective treatment. However, these medications can have serious side effects and require sufficient monitoring to ensure their safe use in treating foster youth.

Up to 80 percent of foster youth enter DHS custody with significant mental health needs and approximately 19% of Oregon foster youth are treated with psychotropic medication. Office of Inspector General (OIG) report, September 2018, "Treatment Planning and Medication Monitoring Were Lacking for Children in Foster Care Receiving Psychotropic Medication." The OIG goes on to recommend psychotropic medication monitoring to reduce the risk to foster youth.

Due to multiple placement or provider changes, delays in initial assessments, unmanageable caseloads, and other factors, foster youth may lack an informed or consistent adult to provide continuous oversight of the youth's mental health treatment. Therefore, foster youth may be at risk for inappropriate prescribing practices including too many medications, incorrect dosage, incorrect duration, or incorrect indications for use. The National Conference of State Legislatures' Child Welfare Project conducted research substantiating concerns surrounding the administration of psychotropic medications for foster youth including but not limited to the use of such medications in young children between 3-6 years of age. Clinicians also report that ineffective monitoring exacerbates the risk of inappropriate dosing, frequent medication switches, or the use of inappropriate medication combinations. *See* "Practice Parameter on the Use of Psychotropic Medication in Children and Adolescents."

Ultimately, HB 2333 provides critical and much needed oversight of foster youth with mental health needs and monitoring of safe prescribing patterns.

Disability Rights Oregon (DRO)

For more than 40 years, DRO has served as Oregon's federally authorized and funded Protection & Advocacy System. DRO is committed to ensuring the civil rights of all people are protected and enforced, including youth in correctional settings.

U.S. Department of Health and Human Services

Office of Inspector General

Treatment Planning and Medication Monitoring Were Lacking for Children in Foster Care Receiving Psychotropic Medication

OEI-07-15-00380

September 2018

Daniel R. Levinson
Inspector General

Report in Brief
September 2018
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U.S. Department of Health and Human Services
Office of Inspector General

Treatment Planning and Medication Monitoring Were Lacking for Children in Foster Care Receiving Psychotropic Medication

What OIG Found

In five States, one in three children in foster care who were treated with psychotropic medications did not receive treatment planning or medication monitoring as required by States. Additionally, the Administration for Children and Families (ACF) has suggested that States consider practice guidelines from professional organizations, including the American Academy of Child and Adolescent Psychiatry, (AACAP) related to treatment planning and medication monitoring. We found that State requirements for oversight of psychotropic medication did not always incorporate these professional practice guidelines.

Treatment planning is critical to enhancing continuity of care; improving coordination of services between health and child welfare professionals; and reducing the risk of harmful side effects. Effective medication monitoring can reduce the risk of inappropriate dosing and inappropriate medication combinations.

Key Takeaway
The five States we reviewed partially complied with their own State requirements for treatment planning and medication monitoring for children in foster care receiving psychotropic medication. Improved compliance and stronger State requirements will help protect children who are at risk for inappropriate treatment and inappropriate prescribing practices.

What OIG Recommends

To ensure coordinated care for children in foster care who receive psychotropic medications, we recommend that ACF develop a comprehensive strategy to improve States' compliance with requirements related to treatment planning and medication monitoring for psychotropic medications. ACF should assist States in strengthening their requirements for oversight of psychotropic medications by incorporating suggested professional practice guidelines for monitoring children at the individual level. ACF stated that it concurred with some of our recommendations but not others; it did not specify which of the two formal recommendations it agreed with, and which it did not. OIG continues to recommend additional action by ACF as actions to date have not led to the needed outcomes.

Full report can be found at oig.hhs.gov/oei/reports/oei-07-15-00380.asp

Why OIG Did This Review

Up to 80 percent of children enter foster care with significant mental health needs. For children with mental health needs, psychotropic medications (i.e., medication used to treat clinical psychiatric symptoms or mental disorders such as depression, bipolar disorder, and schizophrenia) may be effective treatments. However, these medications can have serious side effects and, as ACF suggests and the five States in our sample require, should be used in conjunction with treatment planning mechanisms and effective medication monitoring.

A 2015 OIG report found—based on review of medical records—serious quality-of-care concerns in the treatment of children with psychotropic medications.

How OIG Did This Review

We selected a sample of 625 children in foster care from the 5 States that had the highest utilization of psychotropic medications in their foster care populations. On the basis of foster care case file documentation and Medicaid claims data, we determined the extent to which the children in our sample were treated with psychotropic medications in a manner consistent with their respective States' requirements. Additionally, we compared the five States' requirements for psychotropic medication oversight with treatment planning and medication monitoring practice guidelines from the American Academy of Child and Adolescent Psychiatry.

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BACKGROUND

Objectives

For the five States with the highest percentages of children in foster care treated with psychotropic medications:

1. to assess the extent to which children in foster care who were treated with psychotropic medications received treatment planning and medication monitoring consistent with States' requirements; and
2. to assess the extent to which States incorporate suggested professional practice guidelines for treatment planning and medication monitoring into their requirements for treatment of children with psychotropic medications.

In 2012, nearly 30 percent of the 400,000 children in foster care in the United States were taking at least one psychotropic medication.[1] Psychotropic medications are often used to treat clinical psychiatric symptoms or mental health disorders such as depression, bipolar disorder, schizophrenia, attention deficit/hyperactivity disorder (ADHD), post-traumatic stress disorder (PTSD), and anxiety disorders.[2, 3] Psychotropic medications can be effective treatments for children who have mental health needs, including children in foster care.[4] However, these medications can have serious side effects, such as drowsiness, weight gain, nausea, headaches, involuntary movements, and tremors, among others.[5] There is limited research to guide the use of psychotropic medications in children.[6] Therefore, psychotropic medications are to be used with care and as part of a comprehensive treatment plan.[7]

Many factors related to foster care can complicate efforts to provide appropriate mental health treatment. Up to 80 percent of children in foster care enter State custody with significant mental health needs.[8] Unlike children from intact families, children in foster care often do not have a consistent interested party to coordinate treatment planning or to provide continuous oversight of their mental health treatment.[9] Further, responsibility for children in foster care is shared among multiple people—foster parents, birth parents, and caseworkers—which creates risk of miscommunication, conflict, and lack of followup.[10] Children in foster care may also experience multiple changes in placement and in physicians, which can cause health information about these children to be incomplete and spread across many sources.[11] Therefore, children in foster care may be at risk for inappropriate prescribing practices (e.g., too many medications, incorrect dosage, incorrect duration, incorrect indications for use, or inappropriate treatment).[12]

Effective ongoing oversight of children's care and monitoring of prescribing patterns has several potential benefits, such as enhanced continuity of care, increased placement stability, reduced need for psychiatric hospitalization, and decreased incidence of adverse drug reactions and dangerous drug-to-drug interactions.[13] Ineffective monitoring may increase the risk for inappropriate dosing, frequent medication switches, or the use of inappropriate medication combinations.[14] For example, if a prescriber is unaware that medications are not being taken as ordered, the prescriber may conclude that the existing medication regimen is inadequate and increase a dose or add another medication.[15]

A March 2015 Office of Inspector General (OIG) report found that children enrolled in Medicaid—including children in foster care—experienced quality-of-care issues related to their treatment with antipsychotic medications, which are a type of psychotropic medication. Two of the common quality-of-care issues that we identified through reviewing medical records were related to treatment and monitoring.[16]

Medicaid pays for a majority of the healthcare services that children in foster care receive, including psychotropic medications.[17] In 2013, State Medicaid programs paid approximately $366 million for psychotropic medications for nearly 240,000 children in foster care up to age 21.[18]

The Administration for Children and Families' (ACF) Oversight of State Foster Care Program Requirements

ACF is responsible for awarding Federal funding to States' child welfare programs and for overseeing those programs.

ACF Requirements for State Plans. ACF requires the State agency that administers the State's child welfare program to submit a State plan every 5 years, which outlines how it will comply with Federal requirements. As part of its State plan submission, each State must include a healthcare coordination and oversight plan. The State child welfare agency develops this plan with the State Medicaid agency, pediatricians, other healthcare experts, child welfare service experts, and recipients of these services. The plan addresses the oversight of prescription medicines, including requirements for monitoring the appropriate use of psychotropic medications.[19, 20] The plan must address five elements (listed in Appendix A).[21] Annually, ACF requires each State child welfare agency to describe in its Annual Progress and Service Report its protocols (official procedures used to accomplish the State plan) related to each of the five elements and provide additional information on how the child welfare workforce and providers are trained with regard to these requirements.[22] Hereinafter, we refer to State agency as State and protocols as State requirements.

As noted earlier, previous OIG work has identified (through review of medical records) issues with children receiving inappropriate treatment and monitoring. Two of the five elements ACF requires to be part of a State's

plan include: (1) screening, assessment, and treatment planning mechanisms to identify children's mental health needs and trauma-treatment needs, including a psychiatric evaluation, as necessary, to identify whether children need psychotropic medications; and (2) effective medication monitoring at both the client level and agency level.[23] Client-level monitoring—in this case, child-level monitoring—refers to monitoring an individual who receives medication. Child-level monitoring can include practices such as employing nurses to ensure that individual children receive necessary services or requiring review of individual prescriptions.[24] Agency-level monitoring—in this case, State-level monitoring—refers to activities that support and inform decisions for all clients of an agency. State-level monitoring could involve a State's monitoring the rate at which children in foster care receive psychotropic medication, monitoring the types of psychotropic medications children receive, or establishing an advisory committee to oversee its medication formulary.[25]

ACF Oversight of State Compliance. ACF oversight includes periodic reviews of each State's child welfare system, known as Child and Family Services Reviews, to assess whether a State complies with its State plan requirements.[26] In this report, we refer to these reviews as compliance reviews. ACF determines compliance (i.e., substantial conformity) based on a number of factors, including the State's ability to meet criteria related to outcomes for children and families.[27] In making its assessment, ACF uses a compliance review instrument that assesses particular criteria and makes a determination based on the entirety of the review.

If ACF finds that a State is not in substantial conformity with its State plan, it requires that the State develop a program improvement plan.[28, 29] If the State fails to successfully complete a program improvement plan, ACF has the authority to withhold a certain amount of Federal funding.[30]

The mental/behavioral health section of the compliance review instrument includes an assessment of needs, and services that the State provided to meet those needs, for a sample of children in foster care. The instrument includes criteria such as (1) ensuring the child was seen regularly by the physician to monitor the effectiveness of medication, assess side effects, and consider any changes needed in dosage; (2) regularly following up with foster parents/caregivers about administering medications appropriately and outcomes and side effects.[31]

Guidance on Oversight of Psychotropic Medications for Children in Foster Care

ACF's instruction to States regarding development of requirements related to screening, assessment, treatment planning, and effective medication monitoring is broad. For example, ACF has not established requirements defining the periodicity of the screening, the assessment tools that should be used, or the details that should be included in the treatment plan.

ACF has suggested that States consider practice guidelines from professional organizations related to treatment planning and medication monitoring in efforts to improve their monitoring and oversight requirements of psychotropic medications. These organizations include the American Academy of Child and Adolescent Psychiatry (AACAP), the American Academy of Pediatrics, and prescription parameters developed by the State of Texas, which detail mechanisms that may be used to accomplish the broad requirements.[32] ACF highlighted the AACAP guidelines as particularly relevant to States when developing their psychotropic medication oversight and monitoring requirements. However, ACF instruction acknowledges that States are unique and does not mandate States to incorporate professional practice guidelines in their requirements.

Professional practice guidelines highlight the importance of treatment planning and medication monitoring for children prescribed psychotropic medications.[33] Treatment planning should include collaboration among caregivers to discuss symptoms, behaviors, and potential benefits and side effects of treatment options.[34] This allows all parties to understand why medication is being used and the plan for followup.[35] Medication monitoring visits should occur regularly to enhance patient and guardian confidence in the treatment, and to promote effective management of longer term treatment and safety issues.[36] Specifically, medication monitoring enables prescribing professionals, patients, and guardians to establish a plan for followup and reduce the risk for an unidentified relapse or recurrence of symptoms.[37]

Methodology

Scope

For five States, we determined whether children in foster care were treated with psychotropic medications consistent with their States' requirements related to: (1) screening, assessment, and treatment planning mechanisms, including (as necessary) psychiatric evaluations; and (2) medication monitoring. This study focuses on these two elements because of the quality-of-care concerns that we identified in previous OIG work.

We also determined the extent to which these State requirements were consistent with suggested professional practice guidelines focused on treatment of children with psychotropic medications.

In the States we reviewed, requirements related to screening and assessment applied only to children *entering* foster care. There was not a significant number of sampled children who entered foster care during the review period. Therefore, we were not able to project results related to screening and assessment requirements in the study.

Further, according to the States' requirements, psychiatric evaluations are required only "as necessary," or "if recommended." Because case files did not consistently document the need for psychiatric evaluation, we could not

assess compliance with this conditional requirement. Therefore, we were not able to project results related to psychiatric evaluation requirements.

State and Sample Selection

We selected the five States with the highest percentages of children in foster care who were treated with psychotropic medications in FY 2013, the most recent year for which there was complete data available in the Medicaid Statistical Information System (MSIS).[38] They were Iowa, Maine, New Hampshire, North Dakota, and Virginia.

We combined foster care eligibility data and Medicaid claims data obtained from the five States to determine the population of children in foster care treated with psychotropic medication during the review period, October 1, 2014, through March 31, 2015. From that population, we selected a simple random sample of 125 children from each of the 5 States, for a total of 625 children. We excluded 36 children for various reasons, such as the child's not having been in foster care for a sufficient time (see Appendix B).

Collection and analysis of documentation and data. For each child in our sample, we requested documentation from foster care case files and Medicaid claims data representing services received during the review period. We determined whether any services represented evidence that a required element—screening, assessment, treatment planning, psychiatric evaluation, and/or medication monitoring—occurred. For each instance of a requirement that the State appeared to have not met, we invited the State to provide additional evidence.

Comparing States' Requirements to Practice Guidelines Recommended by AACAP

ACF suggested States consider professional practice guidelines for improving their monitoring and oversight of psychotropic medications.[39] We selected professional practice guidelines from AACAP guidance documents for comparison with the five States' requirements for oversight regarding psychotropic medication.[40] See Appendix B for a detailed description of our methodology.

Limitations

Our estimates cannot be generalized beyond the five selected States.

It is possible that some children in our sample received healthcare services that were not paid for by Medicaid or were not included in the data submitted; therefore, this study may have underestimated the provision of required health services for these children.[41]

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

One in three children in foster care who were treated with psychotropic medications did not receive required treatment planning or medication monitoring

Thirty-four percent of children in foster care who were treated with psychotropic medications, in the five States we reviewed, did not receive either treatment planning or medication monitoring (see Exhibit 1). Eight percent of these children received neither treatment planning nor medication monitoring. Treatment planning and effective medication monitoring are imperative because of the risks of inappropriate treatment and inappropriate prescribing practices (e.g., too many medications, incorrect dosage, incorrect duration, incorrect indications for use). See Appendix C for more information regarding States' compliance with each requirement we reviewed.

Exhibit 1: One in three children in foster care who were treated with psychotropic medications did not receive required treatment planning or medication monitoring

Note: Results are rounded.

Source: OIG analysis of State foster care case files and Medicaid claims for children in foster care, 2017.

See Appendix D for all point estimates and corresponding 95-percent confidence intervals.

Twenty percent of children in foster care did not receive treatment planning

In the five States reviewed, 20 percent of children did not receive treatment planning, as States required. Effective treatment planning provides a mechanism for caseworkers, foster parents, and prescribers to be aware of medications the child is receiving. For children in foster care, effective treatment planning is critical to enhancing continuity of care, improving coordination of services between health and child welfare professionals, and reducing the risk of harmful side effects.

In the following example, there was no evidence that a treatment plan was developed before starting the medication of a child in foster care. However, the child did receive a retrospective review of the four psychotropic medications prescribed. This review indicated concerns regarding the medical necessity of the child's drug regimen that should have been considered and documented in a treatment plan. Without a treatment plan, there is no evidence that the child's caregivers understood important concerns before medicating this child, such as (1) the rationale for each medication, (2) the potential benefits and side effects of each medication, and (3) the plan for followup.

Child Description—6-year-old child diagnosed with ADHD, behavior disorder, learning disability, tic disorder, dysarthria (speech disorder), oppositional defiant disorder, PTSD, trichotillomania (hair-pulling disorder). Prescribed four psychotropic medications.

Case Narrative—The State-employed nurse coordinator noted her opinion that the medications "were quite a bit for a child of his age," and initiated a referral for a medication review. The medication review indicated that the psychiatrist reviewer had questions regarding two of the four medications prescribed to this child. He acknowledged that current medication use could have been within the standard of care. However, there were questions concerning the following: (1) medical necessity for one of the medications; (2) side effects of one medication that could be exacerbating one of the child's conditions; and (3) a dosage increase in one medication that could have negated the need for the fourth medication. The medical review resulted in correspondence with the prescribing professional regarding the medical necessity for two of the child's four medications. Subsequent to this review, the child's drug regimen was changed.

In three of five States, over half of the children who received treatment planning did not have a complete treatment plan. Three of the five States have specific criteria for treatment plans. In those States, 52 percent of children who received treatment planning had plans that did not meet all State criteria. See Appendix C for each of the States' specific criteria for treatment plans, as well as the percentage of children for whom treatment plans did not meet all State-required criteria. Examples of State criteria for treatment plans in those three States include documentation of: diagnoses, assessment summaries, interventions, treatment progress, information about prescribed medications, and evidence of collaboration by a multidisciplinary team. Including these criteria in treatment plans helps caregivers to understand why medication is being used and the plan for followup. Further, treatment planning provides a mechanism for caregivers

to collaborate to assess target symptoms, behaviors, potential benefits, and adverse effects of treatment.

Twenty-three percent of children in foster care did not receive medication monitoring

In the five states we reviewed, 23 percent of children did not receive medication monitoring during the review period. Effective medication monitoring can reduce the risk of inappropriate dosing or inappropriate combinations of medications. For example, if a prescriber is unaware that medications are not provided as planned, the prescriber may unknowingly increase a dose or add another medication.

Medication monitoring is essential for children in foster care to promote communication among prescribing professionals, patients, and guardians, and to establish a plan for followup. Further, medication monitoring can reduce the risk for an unidentified recurrence of symptoms and promote effective management of longer term treatment and safety issues.

States acknowledged challenges in providing required services related to oversight of psychotropic medication for children in foster care

In the five States we reviewed, officials reported challenges in State plan implementation that can pose barriers to providing required services for children in foster care. These challenges included a lack of data for measuring outcomes and limited access to mental health services. Additionally, States noted that some gaps in meeting their requirements are related to transitions in the case-management workforce, developing effective accountability measures for caseworkers, and appropriate training for new caseworkers. Officials reported a need for additional guidance and technical assistance from ACF related to oversight of psychotropic medications prescribed to children in foster care.

States proposed some guidance and assistance that would be helpful to mitigate barriers to providing required services, including:

- national data for States to use as benchmarks in measuring their progress toward meeting the requirements;
- successful policy and practice strategies that have been used by other States to meet requirements; and
- assistance in improving communication between Medicaid and child welfare systems to facilitate the tracking of services provided to children in foster care and measure progress in meeting requirements.

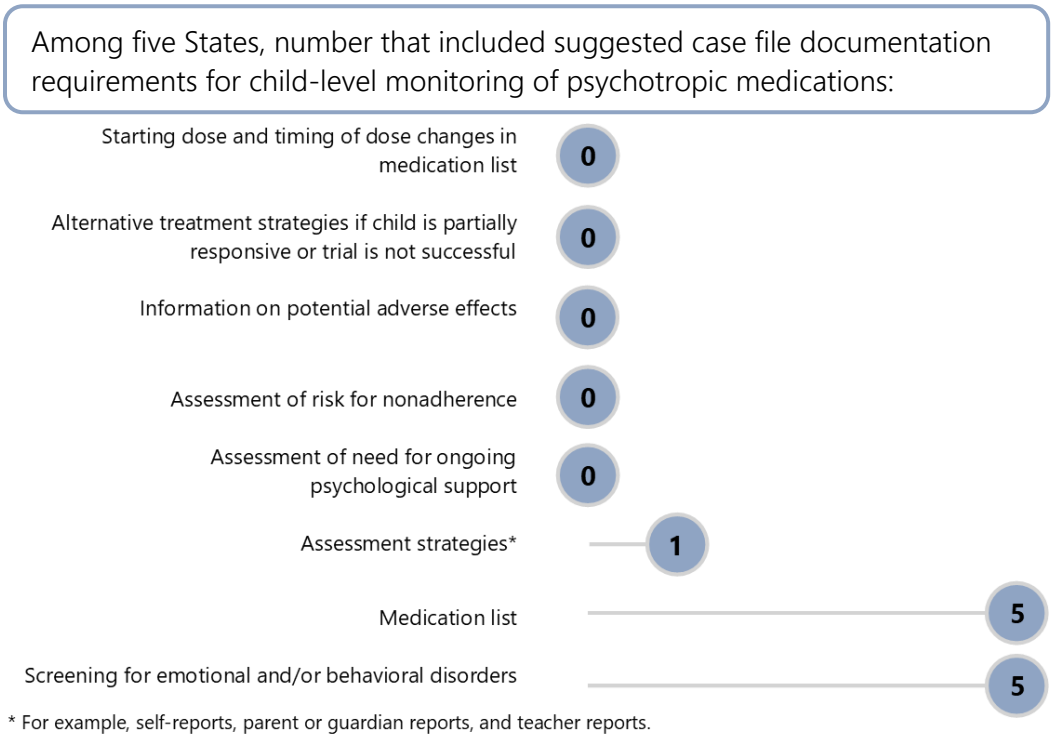
State requirements for psychotropic medication oversight did not always incorporate suggested professional practice guidelines for treatment planning and medication monitoring

In the five States we reviewed, State requirements did not always incorporate professional practice guidelines regarding oversight of psychotropic medications for children in foster care, as suggested by ACF. Although ACF requires State plans to protect children by including treatment planning mechanisms and effective medication monitoring, it allows States flexibility in implementation. ACF suggests that States consider practice guidelines from professional organizations, including AACAP, to improve their treatment planning and medication monitoring requirements.

The five States' requirements did not consistently incorporate professional practice guidelines for child-level monitoring

Our review of five States found that State requirements did not always incorporate these recommendations related to child-level treatment planning and medication monitoring (see Exhibit 2). For example, none of the five States we reviewed included requirements to document medication dosages or potential adverse effects of medications within children's foster care case files.

Exhibit 2: States' requirements did not consistently incorporate elements of suggested professional practice guidelines for child-level oversight of psychotropic medication



* For example, self-reports, parent or guardian reports, and teacher reports.
Source: OIG analysis of selected AACAP recommendations compared with States' requirements, 2017

Specifically, State child-level requirements did not include elements such as information on potential adverse effects or assessment of risk for nonadherence to the treatment plan. These elements provide essential information to accomplish effective oversight, to monitor prescribing, and

to enhance continuity of care. Without these child-level requirements, there is no mechanism to ensure that caregivers are consistently collaborating to assess target symptoms, behaviors, potential benefits, and adverse effects of treatment.

Child-level practice guidelines promote a coordinated strategy in oversight of individual children's psychotropic medication use. This guidance is critical due to known concerns in the foster care population, such as complex mental healthcare needs and changes in foster home placement. These concerns increase the risk of miscommunication among caregivers and ineffective and inappropriate medications or medication combinations. Additionally, previous work by the Government Accountability Office (GAO) concluded that States that do not incorporate AACAP's recommended elements limit their ability to identify potentially risky prescribing practices.[42]

The following example highlights the importance of State child-level requirements. In this State, there is no requirement for caseworkers to follow up with foster parents about medication and the child's outcomes or assess the risk for medication nonadherence. The child was without prescribed medication for a time and experienced adverse effects. There was no evidence in the case file that the caseworker was aware of the nonadherence and the impact on the child's outcome.

Child Description—11-year-old child diagnosed with reactive attachment disorder, conduct disorder, anxiety, and ADHD. Prescribed two psychotropic medications.

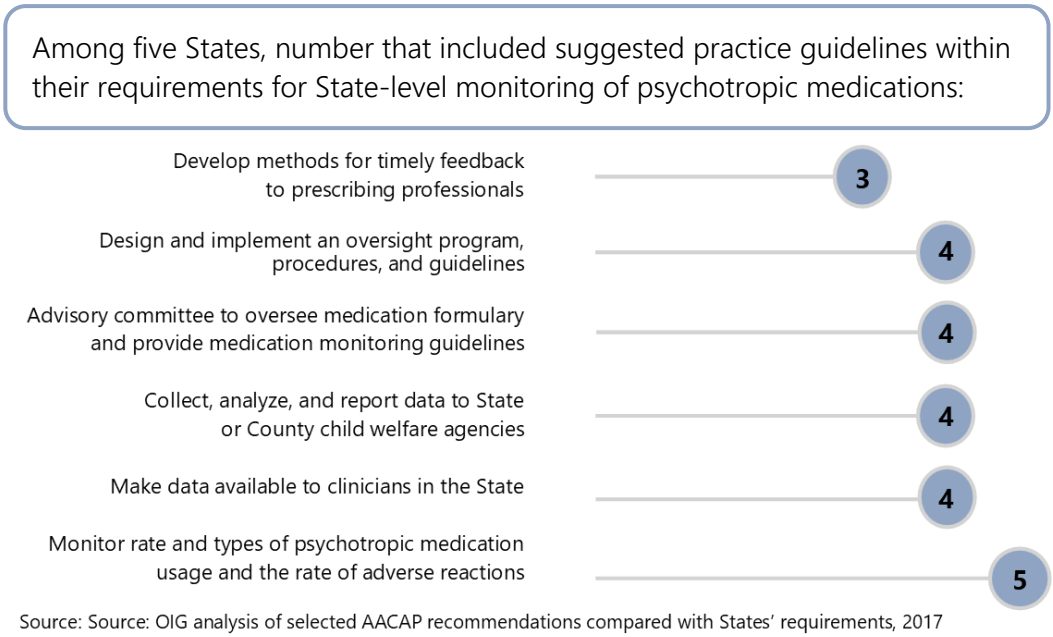
Case Narrative—The child experienced a 3-month period during which the foster mother stated she had difficulties obtaining medication refills for the child. Two prescribing professionals said the child needed to be seen first by a psychiatrist. One prescriber agreed to provide a refill because the child was unmanageable without medications. The child was seen by a psychiatrist during the fourth month, at which time the notes indicated the child was without medications, had lost the ability to maintain normal psychological function, and had experienced a decline of his overall situation. The decline included increased stealing, lying, bullying, poor interactions with other children, and in-school suspension.

The five States' requirements generally incorporated suggested professional practice guidelines for State-level monitoring

Unlike States' child-level requirements, States' State-level requirements generally incorporated suggested professional practice guidelines (see Exhibit 3, on the next page). For example, States included a requirement to monitor the rates and types of psychotropic medication usage and rates of adverse reactions. These aggregate mechanisms can improve States' ability

to identify potentially risky prescribing practices and to improve oversight of psychotropic medications for children in foster care.

Exhibit 3: States' requirements generally incorporated suggested professional practice guidelines for State-level oversight of psychotropic medication



Source: Source: OIG analysis of selected AACAP recommendations compared with States' requirements, 2017

CONCLUSION AND RECOMMENDATIONS

The five States that we reviewed partially complied with their own State-established requirements for treatment planning and medication monitoring for children in foster care receiving psychotropic medications; further, State requirements did not always include suggested professional practice guidelines designed to protect these children. Specifically, 34 percent of children in foster care who were treated with psychotropic medications did not receive treatment planning or medication monitoring as required. Additionally, States' requirements did not consistently incorporate suggested professional practice guidelines, such as requiring assessment strategies and documenting information on potential adverse effects. Improved compliance and strengthened State requirements are imperative to provide protections for children who are at risk for inappropriate treatment and inappropriate prescribing practices.

To ensure coordinated care for children in foster care receiving psychotropic medications, we recommend that ACF:

Develop a comprehensive strategy to improve States' compliance with requirements related to treatment planning and medication monitoring for psychotropic medication

ACF must ensure that States coordinate care for children in foster care with regard to oversight of psychotropic medication. To do this, ACF should develop a comprehensive strategy that identifies methods for States to improve compliance with requirements for treatment planning and medication monitoring. The strategy should guide ACF in strengthening compliance and identifying gaps that need to be addressed. This will improve transparency and accountability, and assist States in doing the same. The strategy should include, at a minimum:

- providing enhanced training and technical assistance, through collaboration with professional provider organizations, for States related to implementing treatment-planning mechanisms and effective medication monitoring (e.g., continued education for caseworkers and supervisors).

Also, ACF may consider:

- helping States develop effective accountability measures and mechanisms for internal quality review;
- requesting that States report data on treatment planning and medication monitoring to the extent they can provide reliable and consistent data, and then providing the compiled national data to States to use as a benchmark for their progress in meeting requirements; and

- placing increased weight on treatment planning and medication monitoring when determining a State's substantial conformity with plan requirements, changing the assessment instrument as necessary, and following up with enforcement actions when appropriate (e.g., mandating program improvement plans, and, where appropriate, withholding Federal funds).

Assist States in strengthening their requirements for oversight of psychotropic medication by incorporating professional practice guidelines for monitoring children at the individual level

ACF must help States strengthen their requirements by incorporating child-level protections for children in foster care who are treated with psychotropic medications. To do this, ACF should:

- strengthen its annual review of States' protocols to confirm that State requirements incorporate professional practice guidelines related to treatment planning and medication monitoring,
- publish an Information Memorandum regarding specific mechanisms for child-level treatment planning and methods to achieve effective medication monitoring, and
- provide enhanced training and technical assistance for States related to incorporating professional practice guidelines in State protocols through collaboration with professional provider organizations.

Also, ACF may consider:

- providing standardized protocols or templates that include child-level recommendations and implementation strategies that States could adapt to meet local needs.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

ACF stated that it concurred with some of our recommendations but not others; it did not specify which of the two formal recommendations it agreed with, and which it did not. ACF comments addressed various subsections of each of these recommendations. We ask that ACF clarify in its Final Management Decision its concurrence or non-concurrence for each formal recommendation.

OIG recommended that ACF develop a comprehensive strategy to improve States' compliance with requirements related to treatment planning and medication monitoring for psychotropic medication. In response, ACF noted that it already has a well-established approach to program implementation that includes a regulated mechanism to identify and correct compliance issues. However, OIG found that one in three children were not receiving treatment planning or medication monitoring, as required in their respective States, which suggests the current approach to identifying and correcting compliance issues is insufficient and more needs to be done. ACF did agree to assess opportunities to continue to provide technical assistance in this area as well as ensure States are reporting on this requirement through Child and Family Services Plans and annual updates. If ACF does conduct such technical assistance and training activities, in collaboration with professional organizations, this would fulfill the intent of our first recommendation.

However, we encourage ACF to further consider our additional suggestions toward improving States' treatment planning and medication monitoring for children in foster care. We note that ACF disagreed with one of these suggestions related to reporting data on treatment planning and medication monitoring. ACF views this data reporting to be outside the scope of what can be reliably and consistently reported to an administrative data set. ACF notes that, by law, its administrative data set must be both reliable and consistent across the reporting population. OIG agrees that data reporting must be reliable and consistent. We continue to encourage ACF to consider innovative approaches to promote State reporting of basic information on treatment planning and medication monitoring that will be reliable and consistent. Likewise, ACF could actively assist States to develop effective accountability measures and mechanisms for internal quality review and consider placing increased weight in its review of treatment planning and medication monitoring during its compliance reviews of States.

With respect to the second recommendation, OIG recommended that ACF assist States in strengthening their requirements for oversight of psychotropic medication. In response, ACF stated that it is amenable to assessing what additional technical assistance and best practice guidance to provide to States regarding the monitoring of psychotropic medication. ACF described the mechanisms through which it makes technical assistance available to States and noted that, to date, no States have reached out around this area of need. ACF also stated that the Child Welfare Information Gateway will include a new article on improving the use of psychotropic medication for children in foster care. This article may represent a step toward providing technical assistance for States related to incorporating professional practice guidelines in State protocols, one aspect of OIG's recommendation. However, overall, ACF's response did not address the substance of OIG's recommendation. OIG continues to recommend that ACF actively engage with States through various actions. In addition to providing technical assistance, these actions should include strengthening its annual review of States' protocols to confirm that State requirements incorporate professional practice guidelines related to treatment planning and medication monitoring for children at the individual level.

The full text of ACF's comments can be found in Appendix F.

APPENDIX A: Five Required Elements for Monitoring the Appropriate Use of Psychotropic Medications

ACF program instruction directs States to include the following elements in their protocols:

1. comprehensive and coordinated screening, assessment, and treatment planning mechanisms to identify children's mental health and trauma-treatment needs, including a psychiatric evaluation, as necessary, to identify needs for psychotropic medications; and
2. informed and shared decision making and methods for ongoing communication between the prescriber, the child, the child's caregivers, and other stakeholders (e.g., healthcare providers and child welfare worker);
3. effective medication monitoring at both the client level and agency level;
4. availability of mental health expertise and consultation regarding both consent and monitoring issues by a board-certified child and adolescent psychiatrist; and
5. mechanisms for sharing accurate and up-to-date information related to psychotropics with clinicians, child welfare staff, and consumers (e.g., children and caregivers), including both data sharing mechanisms (e.g., integrated information systems) and methods for sharing educational materials.[43]

APPENDIX B: Detailed Methodology

State Selection

We selected the five States with the highest percentages of children in foster care who were treated with psychotropic medications in FY 2013. Our assessment of Medicaid eligibility and claims data determined they were Iowa, Maine, New Hampshire, North Dakota, and Virginia. Appendix E contains further details on demographics and Medicaid fee-for-service (FFS) expenditures in all States.

Exhibit B-1: State Demographics Regarding Children in Foster Care Treated with Psychotropic Medications and Related Medicaid Expenditures

State	Population of Children in Foster Care	Number of Children in Foster Care Treated with Psychotropic Medications	Percentage of Children in Foster Care Treated with Psychotropic Medications	Total Medicaid FFS Expenditures for Psychotropic Medications for Children in Foster Care
Iowa	13,951	4,981	35.7%	$7,135,849
Maine	3,527	1,155	32.7%	$1,600,692
New Hampshire	2,614	944	36.1%	$1,741,581
North Dakota	2,734	1,021	37.3%	$1,184,934
Virginia	14,999	5,584	37.2%	$11,959,404

Source: OIG analysis of MSIS eligibility and prescription drug claims data, 2016.

Collection of States' Data and Requirements

We sent a letter to the administrator of each selected State's foster care agency and to each Medicaid director to request a point of contact to respond to our requests for information. From the points of contact, we requested: (1) foster care eligibility data representing all children enrolled in foster care at any time during the review period; (2) a copy of the State's selected foster care requirements; (3) any supporting documentation accompanying those requirements (such as State policies or required forms); (4) State responses to questions that the team developed regarding how the State has implemented the requirements and any related guidance and technical assistance ACF has provided; and (5) all Medicaid-paid claims for psychotropic medications prescribed to children up to 21 years old between October 1, 2014, and March 31, 2015, from the States' Medicaid Management Information Systems (MMIS).

Sample Selection

We selected a simple random sample of 125 children from each State for a total of 625 children. A total of 36 children were determined to be ineligible

for the sample for one of the following reasons: the child was not in foster care during the review period, the child did not receive a Medicaid-paid psychotropic drug claim during their foster care eligibility or during our review period, the child was not in foster care for at least 30 days of our review period, or other limitations prevented review of the case file. Therefore, the overall weighted response rate was 92 percent. In total, 589 children were analyzed for this review. See Exhibit B-2 below regarding the population and sample sizes for the five States.

Exhibit B-2: Population of Children in Foster Care Enrolled in Medicaid Treated with Psychotropic Medications at Any Time Between October 1, 2014, and March 31, 2015

State	Population Size	Sample Size	Ineligible Sampled Children	Final Analyzed Sampled Children
Iowa	2,166	125	9	116
Maine	566	125	5	120
New Hampshire	244	125	1	124
North Dakota	280	125	7	118
Virginia	2,156	125	14	111
Total	**5,412**	**625**	**36**	**589**

Source: OIG analysis of State foster care case files and Medicaid claims for children in foster care, 2017.

Case File Documentation and Medicaid Claims Data Review

We developed criteria based on the State's selected requirements related to screening, assessment, treatment planning, medication monitoring, and psychiatric evaluation. Using the foster care case file documentation and Medicaid claims data, we reviewed each child's treatment with psychotropic medications according to the State's requirements. For our study period, October 1, 2014 to March 31, 2015, we identified the case file documentation and healthcare services received by each child during the child's foster care eligibility. We then determined whether any of those services represented a required element.

For medication monitoring with a prescribing professional, any Medicaid claim for an evaluation and management visit with a mental health diagnosis was considered to fulfill this requirement.[44] Any documentation in the case file stating that an appointment occurred was considered to have fulfilled this requirement so long as we could determine it was with a prescribing professional or the child's psychotropic medication(s) were discussed. Caseworker notes, narrative, or emails that summarized changes in medication were also considered medication monitoring.

Because States gave minimal definition of treatment plans, we considered any case file documentation that was labeled "treatment plan," "case plan," or "care plan" to have fulfilled the treatment plan requirement.[45] Plans developed by prescribing professionals and/or by foster care caseworkers

were considered to have fulfilled this requirement. Documents developed by schools were not considered to have fulfilled treatment plan requirements.

Analysis of Results

We reviewed foster care case file documentation and Medicaid claims data for each sampled child. If either foster care case file documentation or the Medicaid claims demonstrated receipt of a particular required element by a sampled child, that element was counted as received. If neither the foster care case file documentation nor the Medicaid claims demonstrated receipt of a particular required element by a sampled child, that element was counted as not received.

We followed up with foster care program officials in the five States regarding every child for whom we determined at least one required element was missing. State officials either provided additional documentation showing that the child did receive the element(s) in question, or declined to submit additional documentation. If additional documentation showed that the element(s) were received, we counted those element(s) as received.

Comparing States' Protocols to Professional Practice Guidelines

We selected professional practice guidelines from AACAP guidance documents for comparison with the five States' requirements for oversight regarding psychotropic medication. Specifically, we selected professional practice guidelines related to (1) screening, assessment, psychiatric evaluations, and treatment planning; and (2) medication monitoring. We then assessed the extent to which State requirements incorporated these professional practice guidelines. For example, regarding treatment planning and medication monitoring, we assessed whether States' protocols required inclusion of elements such as assessment for risk of nonadherence, information on adverse effects, assessment strategies, starting dose and timing of dose changes in the medication list.

APPENDIX C: State-by-State Compliance With Psychotropic Medication Requirements

This appendix contains five State-by-State summaries of compliance for selected foster care requirements regarding psychotropic medications.

We reviewed foster care case file documentation and Medicaid claims data representing healthcare services and mental health services received by the sampled children during the review period. We determined whether any of those documents or claims represented evidence that a State-required criteria of treatment planning and medication monitoring was provided.

Each State establishes its own foster care requirements (i.e., protocols) for oversight of psychotropic medications. Each State's requirements are unique; therefore, the criteria that we used to assess consistency with the requirements in each selected State is unique to that State. Additionally, we included a determination for each State of whether each sampled child received medication monitoring by a prescribing professional.

Iowa

Compliance with State-Specific Requirements Based on Foster Care Case File and Medicaid Claims Review

TREATMENT PLANNING

Iowa requires that a treatment plan be developed for the child in foster care.

- 30 percent of children in foster care did not receive a treatment plan

MEDICATION MONITORING

Iowa requires caseworkers to visit children in foster care monthly to: determine whether children are receiving necessary medical care and whether the program plan is providing appropriate and sufficient services; inquire of the foster family the effectiveness of the medications; and document the child's medications, why they were prescribed, and whether they meet the child's needs. We also included a determination of whether each sampled child received medication monitoring by a prescribing professional.

- Children in foster care did not receive the following State-required medication monitoring criteria, as applicable:*
  - 41 percent of children did not have evidence that the caseworker documented whether the child was receiving necessary medical care in their case files
  - 33 percent of children did not have evidence that the caseworker documented whether the program plan was providing appropriate and sufficient services in their case files
  - 83 percent of children did not have evidence that the caseworker inquired of the foster family the effectiveness of the medications in their case files
  - 84 percent of children did not have evidence that the caseworker documented the reason the medication was prescribed in their case files
  - 72 percent of children did not have evidence that the caseworker documented whether the medication was meeting the child's needs in their case files
- 48 percent of children in foster care did not receive medication monitoring by a prescribing professional

HIGHLIGHT OF RELATED STATE PRACTICES

Iowa requires caseworkers to conduct multiple tasks related to medication monitoring during their monthly visits with children in foster care. Tasks include determining whether a child is receiving necessary medical care, inquiring of the foster family the effectiveness of a medication, and determining whether the medication meets the child's needs.

Source: OIG analysis of State foster care case files and Medicaid claims for children in foster care, 2017.
*The figures in this exhibit represent the occurrence of this activity at least once during the review period. However, we note Iowa protocol directs caseworker to complete these tasks monthly.

Maine

Compliance with State-Specific Requirements Based on Foster Care Case File and Medicaid Claims Review

TREATMENT PLANNING

Maine requires that a treatment plan be developed for the child in foster care.

- 28 percent of children in foster care did not receive a treatment plan

MEDICATION MONITORING

Maine requires that children in foster care's medication plans be reviewed quarterly by the treatment provider. Additionally, for children prescribed antipsychotic medication, Maine requires the caseworker to participate in medical or psychiatric appointments where medications are initially discussed and a determination is made to proceed or not, and then at least every 3 months following. We also included a determination of whether each sampled child received medication monitoring by a prescribing professional.

- 26 percent of children in foster care had a medication plan that was not reviewed quarterly by the treatment provider
- For children prescribed antipsychotic medications, 59 percent of children in foster care did not have a caseworker who participated in initial medical or psychiatric appointments and then at least every 3 months following*
- 11 percent of children in foster care did not receive medication monitoring by a prescribing professional

HIGHLIGHT OF RELATED STATE PRACTICES

Maine requires caseworkers to conduct certain tasks when a prescribing professional considers antipsychotic medications as a course of treatment for a child in foster care. Caseworkers must provide the child with a discussion guide on antipsychotic medications, complete a medication consent form, review the child's case with the prescribing professional, and participate in the initial appointment to discuss the medication and then every three months following.

Source: OIG analysis of State foster care case files and Medicaid claims for children in foster care, 2017.
*This estimate is based on a sample size of 39 children. The 95-percent confidence interval for this estimate is 45 percent to 72 percent.

New Hampshire

Compliance with State-Specific Requirements Based on Foster Care Case File and Medicaid Claims Review

TREATMENT PLANNING

New Hampshire requires that a treatment plan be developed for the child in foster care. The treatment plan must include an assessment summary, diagnosis, goals or desired outcomes, incremental steps to goal achievement, interventions, an evaluator's name or signature, and a date.

- 23 percent of children in foster care did not receive a treatment plan
- 76 percent of children in foster care did not receive all State-required treatment planning criteria, as follows:
  - 6 percent of children did not have an assessment summary in their treatment plan
  - 38 percent of children did not have a diagnosis in their treatment plan
  - 3 percent of children did not have goals or desired outcomes in their treatment plan
  - 7 percent of children did not have incremental steps to goal achievement in their treatment plan
  - 6 percent of children did not have interventions in their treatment plan
  - 57 percent of children did not have the evaluator's name/signature/date in their treatment plan

MEDICATION MONITORING

We included a determination of whether each sampled child received medication monitoring by a prescribing professional.

- 22 percent of children in foster care did not receive medication monitoring by a prescribing professional

HIGHLIGHT OF RELATED STATE PRACTICES

New Hampshire employs public health nurse coordinators to assist caseworkers by coordinating healthcare visits, exams and treatment for children in foster care, reviewing healthcare histories, and documenting care planning activities.

Source: OIG analysis of State foster care case files and Medicaid claims for children in foster care, 2017.

North Dakota

Compliance with State-Specific Requirements Based on Foster Care Case File and Medicaid Claims Review

TREATMENT PLANNING

North Dakota requires that a treatment plan be developed for the child in foster care. The plan must include goals or objectives, action steps, information about prescribed medications, documentation of treatment progress, and evidence that the treatment plan was developed by a multidisciplinary team.*

- 7 percent of children in foster care did not receive a treatment plan
- 38 percent of children in foster care did not receive all State-required treatment planning criteria, as follows:
  - 2 percent of children did not have goals or objectives in their treatment plan
  - 8 percent of children did not have action steps for meeting specified goals in their treatment plan
  - 11 percent of children did not have information about prescribed medications in their treatment plan
  - 11 percent of children did not have documentation of treatment progress in their treatment plan
  - 27 percent of children did not receive a treatment plan developed by a multidisciplinary team

MEDICATION MONITORING**

We included a determination of whether each sampled child received medication monitoring by a prescribing professional.

- 2 percent of children in foster care did not receive medication monitoring by a prescribing professional

HIGHLIGHT OF RELATED STATE PRACTICES

North Dakota requires multidisciplinary participation in Child & Family Team meetings for children in foster care. The teams are tasked with reviewing case plans, determining levels of care, writing permanency plans, and developing local policies related to foster care.

Source: OIG analysis of State foster care case files and Medicaid claims for children in foster care, 2017.
*North Dakota protocol does not define the disciplines included in a multidisciplinary team. For this review, we considered this requirement met with evidence of participation by at least two disciplines including: Guardian Ad Litem (GAL), Independent Living Coordinator, social worker, caseworker, practitioner, and therapist.
**North Dakota medication monitoring requirements applied to children in foster care in certain circumstances (e.g., residential treatment facilities and therapeutic foster care). These requirements were not applicable to a significant number of sampled children; therefore, we cannot project compliance with these requirements.

Virginia

Compliance with State-Specific Requirements Based on Foster Care Case File and Medicaid Claims Review

TREATMENT PLANNING

Virginia requires that a treatment plan be developed for the child in foster care. The plan must include the child's strengths and needs, health status including any allergies or health conditions, names and addresses of the child's medical and mental health providers, and a list of the child's medications including psychotropic drugs.

- 7 percent of children in foster care did not receive a treatment plan
- 52 percent of children in foster care did not receive all State-required treatment planning criteria, as follows:
  - 12 percent of children did not have strengths and needs in their treatment plan
  - 25 percent of children did not have health status in their treatment plan
  - 42 percent of children did not have the names and addresses of their medical and mental health providers in their treatment plan
  - 29 percent of children did not have a list of their medications including psychotropic drugs in their treatment plan

MEDICATION MONITORING

We included a determination of whether each sampled child received medication monitoring by a prescribing professional.

- 3 percent of children in foster care did not receive medication monitoring by a prescribing professional

HIGHLIGHT OF RELATED STATE PRACTICES

Virginia's Department of Social Services revised the State's foster care manual in July 2015. Updates included requirements for caseworkers to discuss psychotropic medications with the child and guardian, identify the person in the home responsible for administering and monitoring the medication, communicate the importance of medication adherence, monitor the child's behavior, and report any side effects.

Source: OIG analysis of State foster care case files and Medicaid claims for children in foster care, 2017.

APPENDIX D: Statistical Estimates and Confidence Intervals

Exhibit D-1 contains:

- sample sizes (the number of sample children where we obtained useable outcomes);
- point estimates (made using the outcomes determined on the basis of the number of sample children reviewed, or the sample size); and
- 95-percent confidence intervals (estimates of the error in the point estimates; 95 percent is a strong level of confidence).

Exhibit D-1: Point Estimates, Sample Sizes, and Confidence Intervals

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Five States combined statistics			
Percent of children in foster care treated with psychotropic medications that did not receive treatment planning or medication monitoring	589	33.9%	29.8%–38.3%
Percent of children who did not receive a treatment plan	589	19.5%	15.9%–23.6%
Percent of children who did not receive medication monitoring	589	22.9%	19.2%–27.0%
Percent of children who did not receive treatment planning and medication monitoring	589	8.4%	6.0%–11.7%
In States with specific treatment plan requirements, percent of children who received a treatment plan that did not receive all State-required treatment planning criteria	308	52.0%	44.4%–59.6%
Iowa's specific requirements			
Percent of children who did not receive a treatment plan	116	30.2%	22.7%–38.9%
Percent of children who did not have evidence that the caseworker documented whether the child was receiving necessary medical care in their case files	116	40.5%	32.2%–49.5%
Percent of children who did not have evidence that the caseworker documented whether the program plan was providing appropriate and sufficient services in their case files	116	32.8%	25.0%–41.6%

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Exhibit D-1: Point Estimates, Sample Sizes, and Confidence Intervals (continued)

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Iowa's specific requirements			
Percent of children who did not have evidence that the caseworker inquired of the foster family the effectiveness of the medications in their case files	116	82.8%	75.0%–88.5%
Percent of children who did not have evidence that the caseworker documented the reason the medication was prescribed	116	83.6%	76.0%–89.2%
Percent of children who did not have evidence that the caseworker documented whether the medication was meeting the child's needs	116	72.4%	63.8%–79.6%
Percent of children who did not receive medication monitoring by a prescribing professional	116	48.3%	39.5%–57.1%
Maine's specific requirements			
Percent of children who did not receive a treatment plan	120	27.5%	21.0%–35.1%
Percent of children who did not have their medication plan reviewed quarterly by their treatment provider	120	25.8%	19.5%–33.4%
Percent of children prescribed antipsychotic medication who had no evidence that the caseworker participated in medical or psychiatric appointments where medications were initially discussed and a determination is made to proceed or not, and then at least every 3 months following*	39	59.0%	44.9%–71.7%
Percent of children who did not receive medication monitoring by a prescribing professional	120	10.8%	6.8%–16.8%
New Hampshire's specific requirements			
Percent of children who did not receive a treatment plan	124	23.4%	18.6%–29.0%
Percent of children who did not receive all State-required treatment planning criteria	95	75.8%	69.2%–81.3%
Percent of children who did not have an assessment summary in their treatment plan	95	6.3%	3.6%–10.8%
Percent of children who did not have a diagnosis in their treatment plan	95	37.9%	31.3%–44.9%
Percent of children who did not have goals or desired outcomes in their treatment plan	95	3.2%	1.4%–6.8%

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Exhibit D-1: Point Estimates, Sample Sizes, and Confidence Intervals (continued)

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
New Hampshire's specific requirements			
Percent of children who did not have incremental steps to goal achievement in their treatment plan	95	7.4%	4.4%–12.0%
Percent of children who did not have interventions in their treatment plan	95	6.3%	3.6%–10.8%
Percent of children who did not have the evaluator's name/signature/date in their treatment plan	95	56.8%	49.8%–63.7%
Percent of children who did not receive medication monitoring by a prescribing professional.	124	21.8%	17.1%–27.3%
North Dakota's specific requirements			
Percent of children who did not receive a treatment plan	118	6.8%	4.1%–11.1%
Percent of children who did not receive all State-required treatment planning criteria	110	38.2%	31.7%–45.2%
Percent of children who did not receive goals or objectives in their treatment plan	110	1.8%	0.6%–5.0%
Percent of children who did not receive action steps for meeting specified goals in their treatment plan	110	8.2%	5.1%–12.9%
Percent of children who did not receive information about prescribed medications in their treatment plan	110	10.9%	7.3%–16.1%
Percent of children who did not receive documentation of treatment progress in their treatment plan	110	10.9%	7.3%–16.1%
Percent of children who did not receive a treatment plan developed by a multidisciplinary team	110	27.3%	21.5%–33.9%
Percent of children who did not receive medication monitoring by a prescribing professional	118	1.7%	0.6%–4.7%

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Exhibit D-1: Point Estimates, Sample Sizes, and Confidence Intervals (continued)

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Virginia's specific requirements			
Percent of children who did not receive a treatment plan	111	7.2%	3.7%–13.6%
Percent of children who did not receive all State-required treatment planning criteria	103	51.5%	42.1%–60.7%
Percent of children who did not receive strengths or needs of the child in their treatment plan	103	11.7%	6.8%–19.2%
Percent of children who did not receive a health status, including any allergies or health conditions in their treatment plan	103	25.2%	17.9%–34.3%
Percent of children who did not receive the names and addresses of child's medical and mental health providers in their treatment plan	103	41.7%	32.8%–51.2%
Percent of children who did not receive a list of the child's medications including psychotropic drugs in their treatment plan	103	29.1%	21.3%-38.4%
Percent of children who did not receive medication monitoring by a prescribing professional	111	2.7%	0.9%–7.8%

Source: OIG analysis of State foster care case files and Medicaid claims for children in foster care, 2017.
*We are unable to reliably project the frequency estimates for this item because of the small number of sample occurrences.

APPENDIX E: State Demographics Regarding Children in Foster Care Treated With Psychotropic Medications

For each State, Exhibit E-1 represents the population of children in foster care,[46] the number and percentage of children in foster care who were treated with psychotropic medications,[47] and total Medicaid FFS expenditures for psychotropic medications for children in foster care in FY 2013. These figures are based on MSIS eligibility and prescription drug claims data. For States that cover medications through managed care, the exhibit does not reflect the amounts the managed care organizations (MCOs) paid for psychotropic medications for children in foster care.[48] States such as Arizona and Hawaii do not have FFS expenditures for these drugs because they were all covered through managed care.

Exhibit E-1: State Demographics Regarding Children in Foster Care Treated with Psychotropic Medications and Related Medicaid Expenditures*

State	Population of Children in Foster Care	Number of Children in Foster Care Treated with Psychotropic Medications	Percentage of Children in Foster Care Treated with Psychotropic Medications	Total Medicaid FFS Expenditures for Psychotropic Medications for Children in Foster Care
Alabama	11,709	2,897	24.7%	$4,851,356
Alaska	4,175	672	16.1%	$1,204,665
Arizona	24,731	4,257	17.2%	$0
Arkansas	9,857	2,470	25.1%	$3,415,546
California	147,806	20,064	13.6%	$44,581,405
Colorado	21,155	4,871	23.0%	$9,116,770
Connecticut	5,674	1,532	27.0%	$3,345,982
Delaware	2,254	719	31.9%	$1,465,037
District of Columbia	4,671	613	13.1%	$1,026,092
Florida	65,198	11,228	17.2%	$16,510,753
Georgia	33,033	9,408	28.5%	$12,021,956
Hawaii	5,912	571	9.7%	$0
Idaho**	5,024	1,102	21.9%	$1,515,443
Illinois	53,898	10,109	18.8%	$10,733,426
Indiana	23,912	6,844	28.6%	$14,371,841
Iowa	13,951	4,981	35.7%	$7,135,849

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Exhibit E-1: State Demographics Regarding Children in Foster Care Treated with Psychotropic Medications and Related Medicaid Expenditures* (continued)

State	Population of Children in Foster Care	Number of Children in Foster Care Treated with Psychotropic Medications	Percentage of Children in Foster Care Treated with Psychotropic Medications	Total Medicaid FFS Expenditures for Psychotropic Medications for Foster Children
Kansas	18,319	4,292	23.4%	$3,230,278
Kentucky	18,257	5,657	31.0%	$494,659
Louisiana	13,407	4,017	30.0%	$5,584,262
Maine	3,527	1,155	32.7%	$1,600,692
Maryland	16,030	4,450	27.8%	$9,441,087
Michigan	18,884	4,190	22.2%	$10,193,641
Minnesota	12,446	3,597	28.9%	$4,094,907
Mississippi	7,294	1,891	25.9%	$3,187,730
Missouri	34,817	9,847	28.3%	$26,130,684
Montana	4,861	1,249	25.7%	$2,336,576
Nebraska	13,606	3,882	28.5%	$7,118,577
Nevada	12,100	1,829	15.1%	$3,431,784
New Hampshire	2,614	944	36.1%	$1,741,581
New Jersey	27,856	3,871	13.9%	$387,902
New Mexico	6,450	1,189	18.4%	$53,857
New York	54,099	9,068	16.8%	$9,671,915
North Carolina	23,121	7,004	30.3%	$16,393,851
North Dakota	2,734	1,021	37.3%	$1,184,934
Ohio	35,029	9,196	26.3%	$23,575,138
Oklahoma	11,120	2,267	20.4%	$3,150,116
Oregon	23,331	4,468	19.2%	$4,812,840
Pennsylvania	54,349	11,387	21.0%	$1,377,212
Rhode Island**	4,875	979	20.1%	$178,257
South Carolina	14,087	3,630	25.8%	$3,794,339
South Dakota	4,709	1,304	27.7%	$2,480,728
Tennessee	24,455	6,418	26.2%	$11,017,546
Texas	88,609	23,991	27.1%	$35,762,195
Utah	10,862	3,212	29.6%	$7,954,880
Vermont	2,950	933	31.6%	$1,915,196

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Exhibit E-1: State Demographics Regarding Children in Foster Care Treated with Psychotropic Medications and Related Medicaid Expenditures* (continued)

State	Population of Children in Foster Care	Number of Children in Foster Care Treated with Psychotropic Medications	Percentage of Children in Foster Care Treated with Psychotropic Medications	Total Medicaid FFS Expenditures for Psychotropic Medications for Foster Children
Virginia	14,999	5,584	37.2%	$11,959,404
Washington	27,538	5,035	18.3%	$7,008,379
West Virginia	10,950	3,138	28.7%	$4,163,156
Wisconsin	18,290	4,557	24.9%	$7,289,062
Wyoming	3,805	875	23.0%	$1,542,474
Total:	**1,073,340**	**238,465**	**22.2%**	**$365,555,960**

Source: OIG analysis of MSIS eligibility and prescription drug claims data, 2016.

*Massachusetts is not included in this exhibit because its MSIS eligibility files for FY 2013 were incomplete. The Massachusetts eligibility data included only approximately 1,500 unique identifiers for children in foster care. The population of children in foster care in Massachusetts is known to be significantly higher than 1,500.

**Indicates that complete FY 2013 data was not available in MSIS at the time of data collection; therefore, FY 2012 data was used.

APPENDIX F: Agency Comments

ADMINISTRATION FOR CHILDREN & FAMILIES

Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, D.C. 20201 | www.acf.hhs.gov

07/27/2018

Ms. Suzanne Murrin
Deputy Inspector General for Evaluation and Inspections
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Ms. Murrin:

I am writing to you concerning the Office of Inspector General's (OIG) draft report: *Treatment Planning and Medication Monitoring were Lacking for Children in Foster Care Receiving Medication (Report OEI-07-15-00380).* ACF concurs with some of the OIG's recommendations but not others for the reasons set forth below.

Recommendation 1:
ACF develop a comprehensive strategy to improve State's compliance with requirements related to treatment planning and medication monitoring for psychotropic medications.

ACF Response:
We appreciate the OIG's examination of several states with respect to issues in the implementation of their protocols for the appropriate use and monitoring of psychotropic medications.

As far as establishing a strategic plan specific to this requirement, ACF has a well-established approach to program implementation. No approach can guarantee that compliance issues will not arise. Our approach includes a regulated mechanism to identify and correct any compliance issues. OIG's recommendation would require statutory and regulatory changes to implement.

ACF currently collects administrative data but views data on treatment planning and medication monitoring to be outside the scope of what can be reliably and consistently reported to an administrative data set. The statute requires any data reported to our administrative data set be both reliable and consistent across the reporting population.

We will assess opportunities to continue to provide technical assistance in this area as well as ensure states are reporting on this requirement through the Child and Family Services Plans and its annual updates.

Recommendation 2:
ACF should assist States in strengthening their requirements for oversight of psychiatric medications by incorporating suggested professional practice guidelines for monitoring children at the individual level.

ACF Response:

We are amenable to assessing what additional technical assistance and best practice guidance to provide to states. Let me first highlight how our current technical assistance is structured. The Child Welfare Information Gateway (Information Gateway) develops, disseminates and maintains publications, website pages, general information and guidance on a variety of child welfare topics, including those focused on effectively addressing ongoing challenges related to ensuring the appropriate use of psychotropic medications for children in foster care. The Capacity Building Center for States (Center) seeks to support State and territorial child welfare agencies in building capacity to better serve youth by undertaking efforts and promoting best practices, including those related specifically to psychotropic medication use for children in foster care and accompanying topics such as health and mental health, well-being, continuity of care, and successful transitions to adulthood. Services are available to respond to state-specific needs related to the oversight of psychotropic medications for children in foster care and may involve policy and procedure development, consultation and training design, as well as support for the implementation of related efforts. To date, no state has engaged the Center specifically around this area of need.

We do continue, however, to highlight resources for states as they are developed and as they come to our attention. In July/August 2018 the Information Gateway will spotlight new information on mental health of children and youth in foster care, specifically an article titled, "Improving the Use of Psychotropic Medication for Children in Foster Care: A Resource Center," by the Center for Health Care Strategies, Inc.

In conclusion, ACF believes that while we have statutory and regulatory constraints that prevent us from fully implementing all of OIG's recommendations, we will take full advantage of our technical assistance resources to be responsive to OIG's findings in this report. Please direct any follow-up inquires to Scott Logan of our Office of Legislative Affairs and Budget at (202) 401-4529.

Sincerely,

Steven Wagner
Acting Assistant Secretary
for Children and Families

ACKNOWLEDGMENTS

Jamila Murga served as the team leader for this study, and Dana Squires and Abbi Warmker served as lead analysts. Others in the Office of Evaluation and Inspections who conducted the study include Cody Johnson, Katie Fry, Lesta Newberry, Anna Pechenina, and Andrea Staples. Office of Evaluation and Inspections central office staff who provided support include Althea Hosein and Seta Hovagimian.

This report was prepared under the direction of Brian T. Whitley, Regional Inspector General for Evaluation and Inspections in the Kansas City regional office, and Jennifer E. King, Deputy Regional Inspector General.

To obtain additional information concerning this report or to obtain copies, contact the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

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The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

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The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the healthcare industry concerning the anti-kickback statute and other OIG enforcement authorities.

ENDNOTES

[1] ACF, *Managing Psychotropic Medications for Children and Youth in Foster Care*, 2012. Accessed at http://www.acf.hhs.gov/blog/2012/08/managing-psychotropic-medications-for-children-and-youth-in-foster-care on April 1, 2016.
[2] Centers for Disease Control, *Psychotropic Medication Use Among Adolescents: United States, 2005-2010*, 2013. Accessed at https://www.cdc.gov/nchs/data/databriefs/db135.pdf on July 5, 2017.
[3] National Institute of Mental Health, *Mental Health Medications*, 2016. Accessed at http://www.nimh.nih.gov/health/topics/mental-health-medications/index.shtml on March 31, 2016.
[4] ACF, Information Memorandum ACYF-CB-IM-12-03, 2012. Accessed at https://www.acf.hhs.gov/sites/default/files/cb/im1203.pdf on August 24, 2017.
[5] National Institute of Mental Health, *Mental Health Medications*, 2016. Accessed at http://www.nimh.nih.gov/health/topics/mental-health-medications/index.shtml on March 31, 2016.
[6] ACF, *Managing Psychotropic Medications for Children and Youth in Foster Care*, 2012. Accessed at http://www.acf.hhs.gov/blog/2012/08/managing-psychotropic-medications-for-children-and-youth-in-foster-care on April 1, 2016.
[7] Ibid.
[8] American Academy of Pediatrics (AAP), "Health Care Issues for Children and Adolescents in Foster Care and Kinship Care," *Pediatrics*, Vol. 136, No. 4, 2015. Accessed at http://pediatrics.aappublications.org/content/136/4/e1142 on October 26, 2017.
[9] Michael Naylor, et al, "Psychotropic Medication Management for Youth in State Care: Consent, Oversight, and Policy Considerations," *Child Welfare*, Vol. 86, No. 5, 2007, pp. 175-192.
[10] AAP, *Fostering Health: Health Care for Children and Adolescents in Foster Care 2nd Edition*, 2005. Accessed at https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Fostering-Health.aspx on September 15, 2017.
[11] Ibid.
[12] ACF, Information Memorandum ACYF-CB-IM-12-03, 2012. Accessed at https://www.acf.hhs.gov/sites/default/files/cb/im1203.pdf on August 24, 2017.
[13] Michael Naylor, et al, "Psychotropic Medication Management for Youth in State Care: Consent, Oversight, and Policy Considerations," *Child Welfare* Vol. 86, No. 5, 2007, pp. 175-192.
[14] AACAP, "Practice Parameter on the Use of Psychotropic Medication in Children and Adolescents," *J. Am. Acad. Child Adolesc. Psychiatry*, Vol. 48, No. 9, 2009, pp. 961-973. Accessed at http://www.jaacap.com/article/S0890-8567(09)60156-8/pdf on March 9, 2016.
[15] Ibid.
[16] OIG, *Second-Generation Antipsychotic Drug Use Among Medicaid-Enrolled Children: Quality-of-Care Concerns* (OEI-07-12-00320), March 2015. Accessed at https://oig.hhs.gov/oei/reports/oei-07-12-00320.pdf on October 31, 2017.
[17] In all States, nearly all children in foster care are eligible for Medicaid services. According to section 1902(a)(10)(A)(i)(I) of the Social Security Act (the Act), children in foster care who are eligible for assistance payments through Title IV-E of the Act are mandatorily eligible for Medicaid. Children in foster care who are not eligible under Title IV-E usually qualify for Medicaid through other eligibility categories established by each State. Because most children in foster care are eligible for Medicaid, Medicaid pays for healthcare services for almost all children in foster care.
[18] These expenditures only reflect fee-for-service (FFS) Medicaid payments reflected in Medicaid Statistical Information System (MSIS) data for fiscal year (FY) 2013. This was the most recent complete data available at the time of State selection.
[19] The Act, § 422(b)(15)(A)(1)(v).
[20] Each State is required to submit its health services oversight and coordination plan as part of its CFSP to ACF every 5 years (45 CFR § 1357.15). The most recent plans available during the period of our review cover FYs 2015 through 2019.
[21] ACF, Program Instruction ACYF-CB-PI-12-05, 2012. Accessed at http://www.acf.hhs.gov/sites/default/files/cb/pi1205.pdf on July 30, 2015.
[22] Ibid.
[23] Ibid.
[24] Michael Naylor, et al, "Psychotropic Medication Management for Youth in State Care: Consent, Oversight, and Policy Considerations," *Child Welfare* Vol. 86, No. 5, 2007, pp. 175-192.
[25] Ibid.

[26] The compliance reviews assess State compliance with Federal requirements and the outcomes of the child welfare system. These reviews do not specifically determine whether children in foster care received treatment consistent with States' requirements. ACF, *Child and Family Service Reviews Fact Sheet*. Accessed at https://www.acf.hhs.gov/sites/default/files/cb/cfsr_general_factsheet.pdf on September 15, 2017.
[27] "Substantial conformity" is determined by the State agency's ability to meet various standards and criteria, including its capacity to deliver services leading to improved outcomes for children and families. 45 CFR § 1355.34.
[28] 45 CFR § 1355.34.
[29] 45 CFR § 1355.35(a).
[30] If the State fails to successfully complete a program improvement plan, ACF has the authority to withhold a certain amount of Federal funding for the year under review and each subsequent year until the State either successfully completes a program improvement plan or is found to be operating in substantial conformity. 45 CFR § 1355.33 – 1355.36.
[31] ACF, *CFSR Round 3 Onsite Review Instrument and Instructions*, 2016. Accessed at https://www.acf.hhs.gov/sites/default/files/cb/cfsr_r3_osri.pdf on November 14, 2017.
[32] ACF, Information Memorandum ACYF-CB-IM-12-03, 2012. Accessed at https://www.acf.hhs.gov/sites/default/files/cb/im1203.pdf on August 24, 2017.
[33] The recommendations described in this evaluation are not an exhaustive list of all professional recommendations. We have selected recommendations that are relevant to the scope of this study.
[34] AACAP, *A Guide for Community Child Serving Agencies on Psychotropic Medications for Children and Adolescents*, 2012. Accessed at http://www.aacap.org/app_themes/aacap/docs/press/guide_for_community_child_serving_agencies_on_psychotropic_medications_for_children_and_adolescents_2012.pdf on October 30, 2017.
[35] Ibid.
[36] AACAP, "Practice Parameter on the Use of Psychotropic Medication in Children and Adolescents," *J. Am. Acad. Child Adolesc. Psychiatry*, Vol. 48, No. 9, 2009, pp. 961-973.
[37] Ibid.
[38] We used eligibility and prescription drug files from the MSIS to calculate the total children enrolled in foster care in each State, and the total children who had at least one Medicaid-paid claim for a psychotropic medication in FY 2013. We used FY 2012 data for Idaho and Rhode Island because complete FY 2013 files were not available.
[39] ACF, Program Instruction (ACYF-CB-PI-12-05), April 11, 2012, p. 13. Accessed at http://www.acf.hhs.gov/sites/default/files/cb/pi1205.pdf on July 30, 2015.
[40] States are not mandated to establish requirements consistent with AACAP guidance. Therefore, our analysis does not conclude that States are in error, or have failed to meet requirements, where their requirements are not consistent with AACAP guidance.
[41] Children may receive healthcare from sources such as schools, free health clinics, or a parent's private insurance. Additionally, some of the Medicaid claims data provided for our review included Medicaid Managed Care capitated payments, which did not consistently provide detail regarding the services received by those children.
[42] GAO, HHS Guidance Could Help States Improve Oversight of Psychotropic Prescriptions (GAO-12-270T), 2011. Accessed at http://www.gao.gov/new.items/d12270t.pdf on October 31, 2017.
[43] ACF, *Program Instruction* (ACYF-CB-PI-12-05), April 11, 2012, p. 13. Accessed at http://www.acf.hhs.gov/sites/default/files/cb/pi1205.pdf on July 30, 2015.
[44] We define evaluation and management services as office visits, hospital visits, and consultations provided by qualified healthcare professionals authorized to perform such services within the scope of their practice.
[45] States are required to develop a case plan for each child in foster care. The case plan must include information such as the child's health records, medical problems, and medications. The Act, § 422(a)(8)(A)(ii), § 475(5), and § 475(1)(C).
[46] The figures for the population of children in foster care in each State represent the total unique children that were eligible for Medicaid because of their foster care status at any point during FY 2013.
[47] We considered any child who had at least one Medicaid-paid claim for a psychotropic medication while in foster care to have been treated with psychotropic medications.
[48] Medicaid managed care is a type of healthcare delivery system that provides Medicaid health benefits and services to enrollees through contracted arrangements between State Medicaid agencies and MCOs. MCOs receive a set payment per member per month from the State Medicaid agency for these services. FFS is a type of healthcare delivery system in which healthcare providers are paid for each service provided to Medicaid enrollees.

NATIONAL CONFERENCE OF STATE LEGISLATURES

Mental Health and Foster Care

11/1/2019

Up to 80 percent of children in foster care have significant mental health issues, compared to approximately 18-22 percent of the general population. As a result of these increased mental health issues, foster youth are prescribed psychotropic medications at a much higher rate than non-foster youth, costing the state, through fee-for-service programs such as Medicaid, millions of dollars a year. The American Academy of Pediatrics, Healthy Foster Care American Initiative, identifies mental and behavioral health as the "greatest unmet heath need for children and teens in foster care." Factors contributing to the mental and behavioral health of children and youth in foster care includes the history of complex trauma, frequently changing situations and transitions, broken family relationships, inconsistent and inadequate access to mental health services and the over-prescription of psychotropic medications.

A Foster Care Alumni Study, performed by Casey Family Programs in 2003 found significant disparities in mental health between foster care alumni and the general population. The report, Assessing the Effects of Foster Care: Mental Health Outcomes from the Casey National Alumni Study, 2004 compared 1087 former foster youth and 3547 adults from the general population, matched for age, gender, and race/ethnicity and found the following.

Mental Illness	% of Foster Care Alumni	% of General Adult Population
Post-Traumatic Stress Disorder	21.5	4.5
Major Depressive Episode	15.3	10.6
Modified Social Phobia	11.9	8.9

Mental Illness	% of Foster Care Alumni	% of General Adult Population
Panic Disorder	11.4	3.6
Generalized Anxiety Disorder	9.4	5.1
Alcohol Dependence	3.7	2.0
Drug Dependence	3.6	0.5
Bulimia	2.9	0.4

Mental Health Disparities

Of particular note, considering the high level of complex trauma faced by foster children and youth, is that foster care alumni experienced post-traumatic stress disorder at a rate nearly 5 times higher than the general adult population.

Legislation

NCSL's Child Welfare Project tracks legislation related to the mental health and foster youth in the Child Welfare Legislative Enactments Database. Below are examples of what states have done to address the mental health needs of foster children and youth since 2011.
To see legislation addressing the well-being of children and youth in foster care, check out NCSL's 50-State Wellbeing Legislation 2008-2014.

State	Citation	Behavioral and Mental Health Legislative Enactments
Arizona	*2013 Ariz. Sess. Laws, Chap. 220* *2013 Senate Bill 1375*	Requires the Arizona Department of Economic Security (DES), in collaboration with the Arizona Department of Health Services and the Arizona Health Care Cost Containment System to determine the most efficient and effective way to provide comprehensive medical, dental and behavioral health services for children who are in a foster home, in the custody of DES or in the custody of a probation department; relates to child protective services.
California	*2014 Cal. Stats., Chap. 766* *2014 Assembly Bill 1790*	Requires the State Department of Social Services to convene a stakeholder group to identify barriers to the provision of mental health services by mental health professionals with specialized clinical training in adoption or permanency issues to children receiving those medically necessary specialty mental health services. Requires the stakeholder group to make specific recommendations by Jan. 31, 2016, for voluntary measures to address those barriers, but would provide that those recommendations are

		not binding on any state or local government agency or private entity. Requires the stakeholder group to coordinate with, and endeavor not to duplicate, existing local, state, or national initiatives.
Connecticut	*2013 Conn. Acts, P.A. 178* *2013 Senate Bill 972*	Requires the development of a plan for meeting children's mental, emotional and behavioral health needs; requires the inclusion of certain strategies, including school and community-based mental health services integration and early intervention enhancement; provides for collaboration with emergency mobile psychiatric service providers, training of school resource officers, mental health providers, pediatricians and child care providers, home visitation, and a study on nutrition and psychotropic drugs.
Florida	*2014 Fla. Laws, Chap. 2014-227* *2014 House Bill 561*	Finds that though there are organizations that provide representation to children in dependency proceedings, a child with certain special needs in this system has a particular need for legal services. Requires the court to appoint an attorney for a dependent child who: resides in, or is being considered for placement in, a skilled nursing facility, is prescribed a psychotropic medication and declines it, has a developmental disability, is being placed in, or is considered for placement in, a residential treatment center, or is a victim of human trafficking. Requires the court to ask the Statewide Guardian Ad Litem Office to recommend an attorney willing to work without additional compensation prior to the court appointing an attorney on a compensated basis. Details the requirements of the attorney appointed. Clarifies who will contract with the appointed attorney, the compensation for the appointed attorney and requires the Department of Children and Families to identify and request attorney representation for qualifying children and make rules to administer the bill.
Florida	*2014 Fla. Laws, Chap. 2014-224* *2014 Senate Bill 1666*	Requires physician involvement when evaluating medical neglect of a medically complex child. Revises advertising requirements for adoption services. Provides for the Child Abuse Death Review Committee. Revises standards for Medicaid managed care plan accountability, establishes the criminal offense of unlawful desertion of a child.

Idaho	*2014, Idaho Sess. Laws, Chap. 295* *2014 Senate Bill 1401*	Clarifies responsibility for education of children in state care for child protection or mental health issues.
Illinois	*2014 Ill. Laws, P.A. 808* *2014 House Bill 5598*	Establishes the Custody Relinquishment Prevention Act which creates a pathway for families on the verge of seeking services for their child's serious mental illness or serious emotional disturbance through relinquishment of parental custody to the Department of Children and Family Services, despite the absence of abuse or neglect, to receive services through the appropriate State child-serving agency.
Kansas	*2014, Kan. Sess. Laws, Chap. 115* *2014 House Bill 2515*	Relates to powers, duties and functions transferred to the Kansas department for aging and disability services from the Kansas department for children and families and the department of health and environment, includes medical assistance recovery, community mental health and Medicaid fraud.
Michigan	*2014 Mich. Pub. Acts, Act 274* *2014 House Bill 4694*	Authorizes circuit and district courts, and the family division of the circuit court to adopt and institute a juvenile mental health court, provides the conditions under which such courts shall obtain a memorandum of understanding from specified entities, provides the courts may contract with licensed or accredited treatment providers, provides each court shall determine the eligibility for admittance into each court system.
Michigan	*2014 Mich. Pub. Acts, Act 276*	Relates to the mental health court programs for adults and juveniles, provides the eligibility conditions to be met by adults and juveniles for admittance in a mental health court and the requirements to be maintained once an individual is accepted into the program, provides the services available under the program including substance abuse programs and

	2014 House Bill 4696	vocational opportunities, provides that an exit evaluation should be performed to determine the continuing need for specified services.
Michigan	*2011 Mich. Pub. Acts, Act 63* *2011 House Bill 4526*	Sec. 578: Directs the Department of Human Services and child-placing agencies to use a standardized assessment tool to ensure greater cooperation between the department and the Department of Community Health and to measure the mental health treatment needs of every child supervised by the department.
Minnesota	*2014 Minn. Laws, Chap. 291* *2014 House Bill 2402*	Sec. 9: Juvenile treatment screening team. Amends § 260C.157, subd. 3. Requires screenings to be conducted within 10 working days when the screening is requested for placement in mental health residential treatment and the child is enrolled in Minnesota's Pre-Paid Medical Assistance Program.
Minnesota	*2011 Minn. Laws, Chap. 86* *2011 Senate Bill 1285*	The County Board must arrange for or provide a children's mental health screening for a child receiving child protective services; a child in out-of-home placement; a child for whom parental rights have been terminated; a child found to be delinquent; or a child found to have committed a juvenile petty offense for the third or subsequent time. Provides that a children's mental health screening is not required when an assessment has been performed within the previous 180 days or the child currently is under the care of a mental health professional. When a child is receiving protective services or is in out-of-home placement, the court or county agency must notify a parent or guardian whose parental rights have not been terminated of the potential mental health screening and the option to prevent the screening by notifying the court or county agency in writing.
Montana	*2015 Mont. Laws, Chap. 265* *2015*	Creates a pilot project to improve outcomes for youth in the children's mental health system, requires an interim study of evidence-based outcomes, provides for public participation in development of evidence-based outcomes models, requires collection and analysis of data, provides for development of options for performance-based reimbursement, provides an appropriation.

	House Bill 422	
Montana	*2011 Mont. Laws, Chap. 377* *2011 House Bill 565*	Requires the Department of Public Health and Human Services (DPHHS) to consider placement options in in-state treatment facilities for high-risk children with mental health needs who have multiagency service needs before the department places children out of state. The DPHHS will create rules to ensure that out-of-state placement is a last resort. The rules will establish a procedure for in-state facilities to offer a treatment plan for high-risk children with mental health needs that will be considered by DPHHS before children are placed out of state.
Nevada	*2011 Nev. Stats., Chap. 444* *2011 Senate Bill 371*	Requires appointment of a person who is legally responsible for the psychiatric care of each child who is in the custody of an agency that provides child welfare services. The person appointed is to be responsible for making all decisions concerning services and treatment provided to such children. The law allows the court to appoint the person nominated by the agency or to appoint any other person the court determines is qualified to carry out such duties and responsibilities. To the extent that a parent or legal guardian of the child is able and willing to serve as the person legally responsible for the child's psychiatric care, the parent or guardian must be nominated and appointed pursuant to this law. It also requires the person who is legally responsible for the child's psychiatric care to provide written consent or denial of consent for each appointment or for a course of routine treatment for the child's psychiatric care; to maintain current information concerning the child's medical history and emotional, behavioral and educational needs.
Oklahoma	*2014 Okla. Sess. Laws, Chap. 238* *2014 House Bill 1384*	Creates the Parents' Bill of Rights, prohibits the state from infringing upon parental rights, directs the board of education of a school district to develop a policy listing parental rights related to education, includes sex education, prohibits a surgical procedure on a minor without parental consent, excluding abortion, prohibits a mental health evaluation of a minor without parental consent, provides exceptions, relates to immunizations, provides criminal penalties, requires identity verification.
Oregon	*2014 Or. Laws, Chap. 99*	Establishes a Youth Suicide Intervention and Prevention Coordinator within the State Health Authority, sets forth responsibilities of the coordinator, requires the periodic updating of the Youth Suicide Intervention and Prevention Plan, reestablishes the Youth Suicide

	2014 House Bill 4124	Intervention and Prevention Coordinator with that part of the Authority that works with mental health and addiction issues, includes school student data.
Oregon	*2013 Or. Laws, Chap. 515* *2013 Senate Bill 123*	Requires the Department of Human Services to adopt rules to establish the Oregon Foster Children's Bill of Rights; provides for rights including to obtain health care and mental health care, including services and treatments available without parental consent.
Rhode Island	*2015 R.I. Pub. Laws, Chap. 2015-118* *2015 Senate Bill 572*	Mandates the development of a transition plan by the Department of Children, Youth and Families in collaboration with the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals for all children, under the jurisdiction of the family court, who are developmentally delayed or seriously emotionally disturbed, prior to the child turning a certain age, which addresses housing, placement options, health insurance, education, employment services, mentors and continuing support services.
Rhode Island	*2015 R.I. Pub. Laws, Chap. 2015-130* *2015 House Bill 6016*	Mandates the development of a transition plan by the Department of Children, Youth and Families in collaboration with the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals for all children, under the jurisdiction of the family court, who are developmentally delayed or seriously emotionally disturbed, prior to the child turning a certain age, which addresses housing, placement options, health insurance, education, employment services, mentors and continuing support services.
Tennessee	*2015 Tenn. Pub. Acts 199* *2015 Senate Bill 75*	Relates to the rights of adoptive and foster care families, requires the Department of Children's Services to disclose certain information about children adopted from the department's guardianship to the adoptive family, relates to health, educational, mental and behavioral health information, as well as nationality, ethnic background, race, and religious preference, requires rules to govern the operation of a foster parent advocacy program, provides for investigation of child abuse.
Texas	*2013 Tex. Gen. Laws, Chap. 1143*	Relates to integrating behavioral health and physical health services provided under the Medicaid program using managed care organizations; relates to delivery of mental health, behavioral health, substance abuse, and certain other services.

	2013 Senate Bill 58	
Virginia	*2011 Va. Acts, Chap. 9* *2011 House Bill 1984*	Establishes that, in cases where a child cannot be returned to his or her family or cannot be placed for adoption or where kinship care is not in the best interests of the child, the Department of Social Services shall consider other placements and services that afford the best alternative for protecting the child's welfare. These include family foster care; treatment foster care and residential services; and services such as wraparound, respite, mentoring, adoption support and crisis stabilization that may be in the best interests of the child.
Washington	*2015 Wash. Laws, Chap. 283* *2015 House Bill 1879*	Directs the Health Care Authority to seek proposals to establish an integrated managed health and behavioral health plan for foster children enrolled in Medicaid, requires a second opinion review from a psychiatric expert before approving a prescription for a specified supply of an antipsychotic medication for a person under a specified age who is in foster care.
Washington	*2015 Wash. Laws, Chap. 117* *2015 Senate Bill 5486*	Creates the parents for parents program, relates to the dependency court system, provides that the goal is to increase the permanency and well-being of children in foster care through peer mentoring that increases parental engagement and contributes to family reunification.
Washington	*2012 Wash. Laws, Chap. 232* *2012 House Bill 2536*	Concerns the use of evidence-based practices for the delivery of services to children and juveniles, provides for a baseline assessment of utilization of evidence-based and research-based practices in the areas including child welfare and children's mental health services and recommendations for the reallocation of resources for evidence-based and research-based practices.

Examples of Legislation related to the mental health and foster youth

Psychotropic Medication

Background

Psychotropic medication is used for the treatment of behavioral and mental health problems of children and youth in foster care. Psychotropic medications generally include mood stabilizers, antipsychotics, anti-anxiety medications and stimulants. Over the past decade, psychotropic medication use in children and youth in foster care has increased dramatically. A multi-state, 2009-2010 study by Tufts Clinical and Translational Science Institute (CTSI) estimates that youth in foster care use psychotropic medications at a much higher rate (ranging from 13-52 percent) than youth in the general population (4 percent). Recent research has identified major concerns surrounding the administration of psychotropic medications for children and youth in foster care, including the use of multiple psychotropic medications simultaneously, the use of multiple psychotropic medications before the use of a single medication, and the use of such medications in young children between 3-6 years of age. Additionally, research has demonstrated a great deal of variation in rates of medication use for youth in foster care in different geographic communities. Consequently, there is rising concern about the appropriate use of psychotropic medications for youth in foster care.

Federal Legislation

Child and Family Services Improvement Act:
The Child and Family Services Improvement and Innovation Act of 2011 (Public Law 112-34) includes new language concerning the social-emotional and mental health of children who have experienced maltreatment. State Child and Family Services Plans (five-year strategic plans that set forth the vision and the goals to be accomplished to strengthen the States' child welfare systems) must now include details about how emotional trauma associated with maltreatment and removal is addressed, as well as a description of how the use of psychotropic medications is monitored. Read the Administration for Children, Youth, and Families recent Information Memorandum on the Child and Family Services Improvement Act.
Health Oversight Provisions in the Fostering Connections to Success Act of 2008:
The Fostering Connections to Success and Increasing Adoption Act of 2008 now requires each state to consult with pediatricians and other experts and develop a plan for the oversight and coordination of medical and mental health services, including psychotropic medications, for youth in foster care. Plans for oversight and coordination should:

- Promote collaborative efforts between child welfare agencies, Medicaid, pediatricians, and other experts to monitor and track medical and mental health;
- Include medical and mental health evaluations, both on entry into foster care and periodically while in foster care; and
- Provide continuity of care and oversight of medication use.

State Guidelines

Written policies or guidelines for the use of psychotropic medications for foster care youth vary by state. The CTSI study mentioned above reported that, in 2010, 26 states had written policies regarding psychotropic medication use, while 13 states were developing such a policy, nine states had no policy regarding the use of psychotropic medications, and two states did not participate in the study. In most cases, these written policies or guidelines were housed within the state child welfare agency. Two states reported that their child welfare agency followed the guidelines of other state agencies, specifically the Department of Health and the Medicaid office. A link to the CTSI study is provided below.

California recently released Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care. This three-year project's recommendations include consideration of non-drug treatments to help children and youth in foster care cope with the trauma they have experienced, a preference for FDA-approved medications for children, a restriction on the number of medications that children in care are prescribed and frequent check-ins to adjust medication or to obtain a second opinion before prescribing anything. The report stresses the need for legislation to ensure the guidelines are implemented and enforced. As such, California's legislation is considering several bills (SB 238, SB 253, SB 319, SB 484, and AB 1067) to address the administration of psychotropic medications to children in foster care.

In addition to California's efforts, Connecticut's Department of Children and Families' Psychotropic Medication Advisory Committee released its own Guidelines for Psychotropic Medication Use in Children and Adolescents in 2010.

Further, the Center for Health Care Strategies, Inc., with support from The Annie E. Casey Foundation, operates a Psychotropic Medication Quality Improvement Project which includes a webinar series and a resource center focused on the use of psychotropic medications to treat children and youth in foster care.

Legislation

NCSL's Child Welfare Project tracks legislation related to the psychotropic medications and foster youth in the Child Welfare Legislative Enactments Database. Below is a look at what states have done since 2009 to address the use of psychotropic medications for foster children.

For state legislation from 2008-2014, check out NCSL's Health Oversight for Children and Youth in Foster Care page, which includes legislation on mental and behavioral health, psychotropic medications, dental and vision care, among other health issues affecting children and youth in foster care.

State	Citation	Psychotropic Medication Legislative Enactments
California	*2015 Cal. Stats., Chap. 540* *2015 Senate Bill 484*	Provides group foster homes may use psychotropic medications under specified conditions. Requires the Department of Social Services to compile information on the use of such drugs at group homes and post it on the Department's Internet Website. Requires a methodology to ascertain which homes have a utilization of such drugs that warrants

State	Citation	Psychotropic Medication Legislative Enactments
		additional review. Requires sharing information learned with specified entities. Requires submission of a plan to address identified risks. Requires plan review.
California	*2015 Cal. Stats., Chap. 534* *2015 Senate Bill 238*	Requires the Judicial Council to amend and adopt rules of court and develop appropriate forms for the implementation of specified provisions. Specifies the contents of such rules of court. Requires a report on the number of such medications authorized. Requires specified related training on aspects of taking and administering such medications. Requires foster care public health nurses to receive this training.
California	*2015 Cal. Stats., Chap. 535* *2015 Senate Bill 319*	Requires a foster care public health nurse, as part of medical care planning and coordination, to monitor and oversee the child's use of psychotropic medications. Authorizes such nurse to assist a nonminor dependent to make informed decisions about health care. Authorizes the disclosure of health care and mental health care information to such nurse.
Colorado	*2011 Colo., Sess. Laws, Chap. 102* *2011 Senate Bill 120*	Establishes certain protections for the rights of youth in foster care, except for those in the custody of the Division of Youth Corrections or a state mental hospital, including freedom from administration of prescription medication unless authorized by a physician among others.
Connecticut	*2013 Conn. Acts, P.A. 13-178* *2013 Senate Bill 972*	Requires the development of a plan for meeting children's mental, emotional and behavioral health needs, requires the inclusion of certain strategies, including school and community-based mental health services integration and early intervention enhancement, provides for collaboration with emergency mobile psychiatric service providers, training of school resource officers, mental health providers, pediatricians and child care providers, home visitation, and a study on nutrition and psychotropic drugs.
Florida	*2014 Fla. Laws, Chap. 2014-227* *2014 House Bill 561*	Finds that though there are organizations that provide representation to children in dependency proceedings, a child with certain special needs in this system has a particular need for legal services. Requires the court to appoint an attorney for a dependent child who: resides in, or is being considered for placement in, a skilled nursing facility, is prescribed a psychotropic medication and declines it, has a developmental disability, is being placed in, or is considered for placement in, a residential treatment center, or is a victim of human trafficking. Requires the court to ask the Statewide Guardian Ad Litem Office to recommend an attorney willing to work without additional compensation prior to the court appointing an attorney on a compensated basis. Details the requirements of the attorney appointed. Clarifies who will contract

State	Citation	Psychotropic Medication Legislative Enactments
		with the appointed attorney, the compensation for the appointed attorney and requires the Department of Children and Families to identify and request attorney representation for qualifying children and make rules to administer the bill.
Florida	*2014 Fla. Laws, Chap. 227* *2014 House Bill 461*	Finds that though there are organizations that provide representation to children in dependency proceedings, a child with certain special needs in this system has a particular need for legal services. Requires the court to appoint an attorney for a dependent child who, among other things ,is prescribed a psychotropic medication and declines it,
Illinois	*2011 Ill. Laws, P.A. 245* *2011 House Bill 286*	Creates the Administration of Psychotropic Medications to Children Act. Requires the Department of Children and Family Services to promulgate rules establishing and maintaining standards and procedures to govern the administration of psychotropic medications to children and youth in state care. Such rules shall include administration to youth in correctional facilities, residential facilities, group homes and psychiatric hospitals.
Nevada	*2011 Nev. Stats., Chap. 259* *2011 Senate Bill 246*	Requires a medical facility that accepts custody of children pursuant to a court order to adopt a policy concerning administration and management of medication to such children and to ensure that each employee of the medical facility who will administer medication to a child in the facility receives a copy of and understands the policy. The law imposes the same requirement on 1) a public or private institution or agency to which a juvenile court commits a child, 2) a state facility for detention or commitment of children, 3) a specialized foster home or a group foster home, 4) a child care facility that occasionally or regularly has physical custody of children pursuant to the order of a court, and 5) a treatment facility and any other facility of the Division of Child and Family Services into which a child may be committed by a court order.
Nevada	*2011 Nev. Stats., Chap. 444* *2011 Senate Bill 371*	Requires appointment of a person who is legally responsible for the psychiatric care of each child who is in the custody of an agency that provides child welfare services. The person appointed is to be responsible for making all decisions concerning services, treatment and psychotropic medications provided to such children. The law allows the court to appoint the person nominated by the agency or to appoint any other person the court determines is

State	Citation	Psychotropic Medication Legislative Enactments
		qualified to carry out such duties and responsibilities. To the extent that a parent or legal guardian of the child is able and willing to serve as the person legally responsible for the child's psychiatric care, the parent or guardian must be nominated and appointed pursuant to this law. It also requires the person who is legally responsible for the child's psychiatric care to provide written consent or denial of consent for each appointment or for a course of routine treatment for the child's psychiatric care; to maintain current information concerning the child's medical history and emotional, behavioral and educational needs; and to approve or deny administration of each psychotropic medication recommended for the child. The law prohibits administration of a psychotropic medication to a child in the custody of an agency without consent from the person who is legally responsible for the child's psychiatric care.
Nevada	*2011 Nev. Stats., Chap. 443* *2011 Senate Bill 370*	Sec. 3: Requires a foster home licensee to obtain written explanation from a medical professional who provides a prescription for medication for a foster child. The explanation must include the need for the medication and the effect of the medication.
New Mexico	*2015 N.M. Laws, Chap. 51* *2015 House Bill 53*	Relates to children, enacts a new section of the Public School Code to prohibit school personnel from compelling students to use psychotropic medications, provides that a parent's, guardian's or custodian's refusal to consent to the administration of such medication to a child is not grounds per se for protective custody.
Oregon	*2009 Or. Laws, Chap. 853* *2009 House Bill 3114*	Requires the development of procedures for an assessment by a qualified mental health professional or licensed medical professional prior to the issuance of a prescription to a child in foster care for multiple psychotropic medications. Requires an annual review of prescriptions when a child in foster care has more than a specified number of such medications or is under a specified age. Prohibits prescribing of such medication unless used for a medically accepted indication that is age-appropriate.
Texas	*2013 Tex. Gen. Laws, Chap. 204* *2013 House Bill 915*	Increases accountability and awareness for those making medical decisions by defining informed consent; requires notification of biological parents when there are changes in the psychotropic medication plan for their youth in foster care; strengthens transition plans for foster youth by including resources to manage medications after exiting foster care; requires the authorized

State	Citation	Psychotropic Medication Legislative Enactments
		medical consenter for a foster child who has been prescribed a psychotropic medication to ensure the child sees the prescribing physician at least once every 90 days; strengthens training on psychotropic medications for medical consenters; provides tools to the child's guardian ad litem, attorney ad litem, caseworker, and court to protect the health and safety of a child.
Texas	*2011 Tex. Gen. Laws, Chap. 843* *2011 House Bill 3531*	Requires the Health and Human Services Commission to implement a system under which the commission is to use Medicaid prescription drug data to monitor the prescribing of psychotropic drugs for children who are in care.
Washington	2015 *Wash. Laws, Chap.* 283 *2015 House Bill 1879*	Directs the Health Care Authority to seek proposals to establish an integrated managed health and behavioral health plan for foster children enrolled in Medicaid, requires a second opinion review from a psychiatric expert before approving a prescription for a specified supply of an antipsychotic medication for a person under a specified age who is in foster care.

legislation related to psychotropic medications and foster youth

About This NCSL Project

The Denver-based child welfare project staff focuses on state policy, tracking legislation and providing research and policy analysis, consultation, and technical assistance specifically geared to the legislative audience. Denver staff can be reached at (303) 364-7700 or childwelfare@ncsl.org. NCSL staff in Washington, D.C. track and analyze federal legislation and policy and represent state legislatures on child welfare issues before Congress and the Administration. Staff in D.C. can be reached at (202) 624-5400 or cyf-info@ncsl.org.

Additional Resources

- Mental Health Financing in the United States, The Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, 2011
- Tufts Clinical and Translational Science Institute Multi-State Study on Psychotropic Medication Oversight in Foster Care
- HHS Guidance Could Help States Improve Oversight of Psychotropic Prescriptions [Reissued on Dec. 15, 2011] GAO-12-201
- The U.S. Department of Health & Human Services Administration for Children & Families, Use of Psychotropic Medications Resource Page

- Center for Education and Research on Therapeutics, Antipsychotic Medication Use in Medicaid Children and Adolescents: Report and Resource Guide From a 16-State Study
- American Bar Association, Center on Children and the Law, Practice and Policy Brief: Psychotropic Medication and Children in Foster Care, 2011
- Child Welfare Information Gateway, list of resources
- Mental Health Services for Children Placed in Foster Care: An Overview of Current Challenges, 2009
- American Academy of Pediatrics, Healthy Foster Care American Initiative, Mental and Behavioral Health
- American Psychological Association: CYF News, 2012
- Information Packet: Mental Health Care Issues of Children and Youth in Foster Care, 2008
- Assessing the Effects of Foster Care: Mental Health Outcomes from the Casey National Alumni Study, 2004

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Practice Parameter on the Use of Psychotropic Medication in Children and Adolescents

ABSTRACT

The purpose of this practice parameter is to promote the appropriate and safe use of psychotropic medications in children and adolescents with psychiatric disorders by emphasizing the best practice principles that underlie medication prescribing. The evidence base supporting the use of psychotropic medication for children and adolescents with psychiatric disorders has increased for the past 15 to 20 years, as has their use. It is hoped that clinicians who implement the principles outlined in this parameter will be more likely to use medications with the potential for pharmacological benefit in children safely and to reduce the use of ineffective and inappropriate medications or medication combinations. The best practice principles covered in this parameter include completing a psychiatric and medical evaluation, developing a treatment and monitoring plan, educating the patient and family regarding the child's disorder and the treatment and monitoring plan, completing and documenting assent of the child and consent of the parent, conducting an adequate medication treatment trial, managing the patient who does not respond as expected, establishing procedures to implement before using medication combinations, and following principles for the discontinuation of medication. *J. Am. Acad. Child Adolesc. Psychiatry,* 2009;48(9):961–973. **Key Words:** practice parameter, psychopharmacology, multiple medications, treatment.

During the past 15 to 20 years, there has been a marked increase in our understanding of childhood psychiatric disorders and a developing evidence base for both psychopharmacological and psychosocial treatments. Children are commonly affected by psychiatric disorders, and without treatment, they can experience short- and long-term distress

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This parameter was developed by John Walkup, M.D., principal author, and the Work Group on Quality Issues: William Bernet, M.D., Oscar Bukstein, M.D., M.P.H., and Heather Walter, M.D., M.P.H., Co-Chairs, and Valerie Arnold, M.D., R. Scott Benson, M.D., Joseph Beitchman, M.D., Allan Chrisman, M.D., Tiffany R. Farchione, M.D., John Hamilton, M.D., Helene Keable, M.D., Joan Kinlan, M.D., Jon McClellan, M.D., Ulrich Schoettle, M.D., Jon Shaw, M.D., Matthew Siegel, M.D., and Saundra Stock, M.D. American Academy of Child and Adolescent Psychiatry (AACAP) Staff: Kristin Kroeger Ptakowski and Jennifer Medicus.

AACAP practice parameters are developed by the AACAP Work Group on Quality Issues (WGQI) in accordance with American Medical Association policy. Parameter development is an iterative process between the primary author(s), the WGQI, topic experts, and representatives from multiple constituent groups, including the AACAP membership, relevant AACAP components, the AACAP Assembly of Regional Organizations, and the AACAP Council. Details of the parameter development process can be accessed on the AACAP Web site. Responsibility for parameter content and review rests with the author(s), the WGQI, the WGQI Consensus Group, and the AACAP Council.

The AACAP develops both patient-oriented and clinician-oriented practice parameters. Patient-oriented parameters provide recommendations to guide clinicians toward best treatment practices. Recommendations are based on empirical evidence (when available) and clinical consensus (when not) and are graded according to the strength of the empirical and clinical support. Clinician-oriented parameters provide clinicians with the information (stated as principles) needed to develop practice-based skills. Although empirical evidence may be available to support certain principles, principles are primarily based on expert opinion derived from clinical experience. This parameter is a clinician-oriented parameter.

The primary intended audience for the AACAP practice parameters is child and adolescent psychiatrists; however, the information contained therein may also be useful for other mental health clinicians.

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From September 2006 to December 2007, this parameter was reviewed by a Consensus Group convened by the WGQI. Consensus Group members and their constituent groups were as follows: WGQI (Oscar Bukstein, M.D., Chair, Allan Chrisman, M.D., and Saundra Stock, M.D., Members); Topic Experts (Daniel S. Pine, M.D., and Timothy Wilens, M.D.); AACAP Assembly of Regional Organizations (Susan Daily, M.D.); and AACAP Council (Aradhana Bela Sood, M.D., and Charles Zeanah, Jr., M.D.).

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and impairment. The current evidence base to address the treatment needs of these children comes from high-quality randomized controlled trials for most psychotropic medication classes (e.g., stimulants, antidepressants, antipsychotics) and for a number of manual-based psychotherapeutic approaches.[1]

Despite the advances of the past 2 decades, the vast majority of children with mental health problems still do not receive appropriate evaluative and treatment services.[2] Reports of the increased use of psychotropic medications in children[3,4] suggest that prescribers, parents, and patients view pharmacological treatment as an important intervention to reduce the symptoms of childhood psychiatric disorders. However, reports of increased psychotropic medication use has also led to concerns that some children and adolescents are being overdiagnosed with psychiatric disorders and are being treated with medication/s that are not appropriate for them. Strategies to address the overuse or inappropriate use of medications (e.g., the Food and Drug Administration advisory "black box" warning for antidepressants) may actually create barriers to care (e.g., decreased antidepressant prescription rates[5]) and may result in unintended negative consequences (e.g., increased teen suicide rate[6]). Rather than advocating for restricting access to medication treatment, this parameter advocates for high-quality assessment and prescribing practices to enhance outcomes for children and to address societal concerns about how children with psychiatric disorders are treated.

There is a great range of appropriate psychopharmacological practice, reflecting the range of medical specialties, levels of expertise, and clinical settings of today's prescribers. The principles highlighted in this parameter are not intended to create a uniform approach for all prescribers. A single approach for all prescribers would not be applicable or practical and could inadvertently restrict children in need from access to effective treatments. By focusing on the decision-making principles that underlie optimal psychopharmacological practice, it is hoped that more children will have the opportunity to receive appropriate treatment with medication and reduce the exposure of children to medication interventions that may not be appropriate. Given the focus in this parameter on the best practice principles for using psychotropic medications in children and adolescents, there is limited discussion of the details of the psychiatric evaluation and details about medication and psychosocial treatments for specific disorders. The American Academy of Child and Adolescent Psychiatry (AACAP) practice parameter for psychiatric assessment[7] addresses specific guidelines for the evaluation of children and adolescents, and the AACAP practice parameters for the assessment and treatment of specific disorders[8–13] address the evidence base for psychopharmacological and psychosocial treatments in children and adolescents.

This parameter is divided into five sections: assessment, development of the treatment and monitoring plan, psychoeducation and assent/consent, implementation of the treatment and monitoring plan, and management of complex pharmacological interventions including medication discontinuation.

Prescriber refers to any clinician who has the capacity to evaluate children for and treat children with psychotropic medications (e.g., child and adolescent psychiatrists, general psychiatrists, pediatricians, family doctors, nurse practitioners). *Parents* refer to biological parents or legal guardians. *Disorder* refers to the target of treatment, whether it is a disorder or symptom cluster. *Psychoeducation* refers to the process of imparting information about a disorder and its treatment, both the generic information and information of specific relevance to an individual child and family.

METHODOLOGY

A literature review of relevant articles pertaining to psychopharmacology in children and adults was completed using the PubMed database. In addition, textbooks on pediatric psychopharmacology were reviewed as were their reference lists. In addition, a PubMed search on quality medical care and the overuse of medical testing (e.g., routine laboratory or radiological testing), other medical procedures considered to be used excessively (e.g., cesarean section), and other medical conditions that have historically been overdiagnosed or misdiagnosed and treated inappropriately (e.g., patients with viral infections treated with antibiotics) provided background for this parameter.

GENERAL BACKGROUND

The increased use of psychotropic medications[3,4] and psychotropic medication combinations[14,15] to treat childhood psychiatric disorders reflects a deservedly larger role for medication treatment of childhood psychiatric disorders. A number of factors have likely influenced this increased use including increased support for the biological basis of some childhood psychiatric disorders, a developing evidence base demonstrating the efficacy of psychotropic medications in children and adolescents, advocacy efforts to identify and treat the large number of children with psychiatric disorders, reductions in funding and changing patterns of reimbursement for mental health care, and the marketing efforts of pharmaceutical companies to prescribers and consumers.

Advances in neuroscience suggest that childhood psychiatric disorders can be associated with abnormalities in neurotransmitters and/or structural or functional abnormalities of specific brain regions and/or the circuitry that interconnect

affected brain regions. These abnormalities may be caused by environmental factors, genetic factors, or their combination. Neurobiological explanations of childhood psychiatric disorders are often used to support the use of psychotropic medications for childhood psychiatric disorders (see Martin et al.[15] for a review).

The current evidence base in child psychopharmacology includes basic and clinical research, which supports the safe and effective use of psychotropic medications (e.g., randomized controlled trials, studies of what the body does to the medication [pharmacokinetics], and what the medication does to the body [pharmacodynamics]). Efficacy and safety data are available for single pharmacological agents in the short-term treatment of a number of childhood psychiatric disorders, including attention-deficit/hyperactivity disorder (ADHD)[16]; major depressive disorder[17–20]; obsessive-compulsive disorder (OCD)[21–25]; other anxiety disorders including separation anxiety disorder, social phobia, and generalized anxiety disorders[26–32]; and mania and tic disorders.[33] There is also evidence supporting the use of medications for aggression and serious problems with impulse control in children with disruptive behavior disorders[34,35] and autism.[36] For disorders that present similarly in childhood, adolescence, and adulthood (e.g., schizophrenia), data from adult studies[12] and from extensive clinical practice[8] can guide medication choices for children and adolescents. The evidence for short-term safety and efficacy is complemented by increasing information about the longer term safety and usefulness of some medications in children and adolescents.[37–39]

In contrast to what is known about treatment with a single psychotropic medication, there is a smaller evidence base supporting the efficacy of medication combinations.[40] Psychotropic medication combinations are commonly used to address complex comorbid presentations,[41–43] to enhance outcome for treatment-refractory or partially responsive patients,[43,44] to manage side effects of an effective agent (e.g., anticholinergic medication for extrapyramidal symptoms), or to address symptoms hypothesized to be associated with multiple underlying neurotransmitter abnormalities (e.g., dopamine agonists for hyperactivity and serotonin agonists for anxiety[45]). Although the design of studies of a single medication is relatively straightforward (e.g., randomized controlled trials), studies of medication combinations, combining medication and psychotherapy,[18,32,46] and studies to address the sequence of treatment for complex presentations require more complex study designs[47] and are more costly to implement (e.g., Sequenced Treatment Alternative to Relieve Depression). The cost and complexity of these studies may partially explain the lack of such studies in children and adolescents.

The evidence base on which prescribers depend to make treatment decisions includes a medication's product information as well as the larger medical literature. The product information for a specific medication, developed cooperatively by the pharmaceutical manufacturer and the Food and Drug Administration, generally reflects the evidence from studies sponsored by the pharmaceutical manufacturer, is geared toward marketing for a specific indication, and does not always reflect the evolving evidence base that may include investigator-initiated and federally funded postmarketing studies. Consequently, prescribers may have to rely on the reports of randomized controlled trials in the medical literature, consensus guidelines, and practice parameters, as well as the product information to effectively practice evidence-based psychopharmacology. For some psychiatric disorders, prescribers may use psychotropic medications "off-label" (e.g., selective serotonin reuptake inhibitors [SSRIs] for non-OCD anxiety disorders[26–28,32]) or inconsistent with the product labeling (e.g., stimulants for children with ADHD and tic disorders[42]) to best address the treatment needs of children and adolescents and to be consistent with the standard of care.

Advocacy efforts by the federal government such as Surgeon General Satcher's National Action Report,[2] practitioner organizations (e.g., AACAP, American Academy of Pediatrics, American Psychiatric Association), and family and patient support groups (e.g., National Alliance on Mental Illness, Children and Adults with Attention-Deficit/Hyperactivity Disorder) have educated the public regarding the need for evaluation and treatment services for childhood psychiatric disorders. Advocacy has likely resulted in decreased stigma and increasing interest in and use of mental heath care, including pharmacotherapy.

For the past 10 to 15 years, significant changes in mental health services, including a shortage of child and adolescent psychiatrists, limitations in insurance coverage for inpatient and partial hospital programs, and fewer outpatient psychotherapy services by psychiatrists, may have also contributed to increase in psychotropic medication use.[48,49]

Finally, the increased use of psychotropic medications has been attributed to the direct financial role of the pharmaceutical industry in funding clinical trials,[50] financial support to investigators,[51] for resident training and continuing medical education,[52] and direct-to-consumer advertising.[53] Although it has been repeatedly asserted that financial support for research and medical education at all levels has increased the use of psychotropic medications, it is difficult to quantify and to prove conclusively.[54] Direct-to-consumer advertising on television, which increased dramatically in the mid-1990s, has been posited as eliciting inappropriate demand that leads to inappropriate prescribing, yet direct-to-consumer advertising has also been demonstrated to be a helpful educational tool to increase awareness of treatment options for disorders that are undertreated or stigmatized, such as depression.[55]

The purpose of this practice parameter is to promote the safe and appropriate use of psychotropic medications in children and adolescents with psychiatric disorders by emphasizing the best practice principles that underlie medication prescribing. There are multiple steps involved in the use of psychotropic medication in children and adolescents. First, the prescriber is responsible for completing an evaluation of the patient and family. The evaluation leads to a diagnostic formulation and the development of a psychosocial and psychopharmacological treatment plan based on the best available evidence. The pharmacological treatment plan includes not only an adequate medication trial but also strategies for preparing the patient and family and monitoring outcome and side effects. Before initiating the medication treatment plan, the patient and family need to be educated about the child's problem, treatment options, and the treatment and monitoring plan. The education of the patient and parent sets the stage for obtaining assent for treatment from the child and consent from the parents. Treatment is initiated according to the treatment plan with strategies to monitor for both benefits and side effects. Once the patient is stabilized on medication, monitoring visits occur regularly and predictably enough to enhance the patient's and family's confidence in the treatment and prescriber and to ensure effective management of longer term treatment and safety issues. Finally, if clinically indicated, the clinician, patient, and family identify a time for a medication discontinuation trial and have a plan for follow-up that will allow children to discontinue medication with minimal risk for an unmonitored relapse/recurrence of symptoms.

The prescriber establishes procedures to implement these tasks and uses them routinely to provide high-quality care that integrates the psychopharmacological evidence base, state-of-the-art clinical skills, and the patient's and family's needs and values. The clinician who establishes a high-quality approach to assessment and treatment will hopefully practice more consistently and have patients and families who understand, adhere to, and actively participate in the intervention and assessment of outcome. A proactive and positive approach may also decrease the stigma that some children and their parents experience from participating in psychiatric care. For clinicians who do not use a rigorous consistent approach to assessment and treatment, it is possible that they will introduce unacceptable variability into the pharmacological treatment of children, underuse psychosocial and pharmacological treatment approaches, and succumb to the use of ineffective treatment approaches or inappropriate medications or medication combinations. Children and families who do not receive high-quality mental health care may become demoralized by their care experience and may drop out of treatment or not seek treatment in the future. It is also possible that poor quality of psychiatric care may affect the public's perception of prescribers of psychotropic medications and lead to a loss of public support for psychiatric treatment services.

PRINCIPLES

Assessment

Principle 1. Before Initiating Pharmacotherapy, a Psychiatric Evaluation Is Completed. The psychiatric evaluation[7] is comprehensive enough to identify symptoms best addressed pharmacologically and best addressed with psychosocial treatments and to identify psychosocial factors that may impede an adequate and safe medication trial or confound the assessment of outcome. A comprehensive evaluation increases the likelihood that medication interventions will be well conceptualized and hopefully reduces the likelihood of treatment failure and poor adherence. Attention to psychosocial factors in the evaluation helps to ensure that psychosocial approaches are included in the treatment plan.

The psychiatric evaluation includes interviews with both the child and parents. During the assessment, the confidentiality needs of both the child and parents are balanced against the need for all involved to have a common information base on which to make treatment decisions. A review of previous records to assess past successful and unsuccessful treatments can enhance the likelihood that proposed intervention will be the next logical treatment step and reduce the chance that previously ineffective treatments will be used again.

Principle 2. Before Initiating Pharmacotherapy, a Medical History Is Obtained, and a Medical Evaluation Is Considered When Appropriate. Because a medication intervention in a child is a significant medical event, it is prudent to complete a medical evaluation to ensure that the child has no medical problem accounting for the psychiatric presentation and is healthy enough to participate in a medication trial with minimal risk. For example, the medical history helps to determine whether the child has any current or past medical problems; is taking any medications including prescribed medications, over-the-counter medications, complementary/alternative treatments, or illicit substances; has medication allergies; or has a personal or family history of medical problems associated with increased risk for side effects (e.g., a personal history of a structural cardiac abnormality before starting stimulants or family history of malignant arrhythmias or sudden cardiac death before starting atypical antipsychotics).

Targeted medical testing may be appropriate to establish a medical baseline before initiating medications with known risks (e.g., height and weight for stimulants[13]; height, weight, and lipid testing for antipsychotics[56]). Although a routine history,

physical, and laboratory testing completed by a pediatric specialist is not necessary before starting most psychotropic medications, completing such an evaluation just before starting medication may be useful to document that a child is healthy and establishes a normal baseline. Such a medical screening evaluation may also put the patient, family, and prescriber at ease and thereby facilitate the initiation of the medication trial. Specific recommendations regarding medical screening are included in specific AACAP practice parameters for disorders for which medication treatments have proven benefit (e.g., ADHD, anxiety disorders, mood disorders).

Principle 3. The Prescriber Is Advised to Communicate With Other Professionals Involved With the Child to Obtain Collateral History and Set the Stage for Monitoring Outcome and Side Effects During the Medication Trial. Good communication and coordination among medical, mental health, and education professionals involved in the child's life is important for the safe and effective use of psychotropic medications. Communicating with these professionals during the evaluation process ensures that the evaluation is complete and sets the stage for subsequent interactions during treatment. Early communication also elicits the support of key professionals for the treatment plan (e.g., pediatricians who provide ongoing medical care, school nurses who may dispense medication, teachers who may be involved in evaluating the outcome) and may reduce the chance of misunderstandings during treatment. Follow-up among professionals during treatment enables all professionals involved to be up to date with the treatment plan and that treatment is well coordinated.

Treatment and Monitoring Plan

Principle 4. The Prescriber Develops a Psychosocial and Psychopharmacological Treatment Plan Based on the Best Available Evidence. After completing the evaluation, the prescriber organizes the case material into a diagnostic formulation that considers biological, psychological, and social etiologies for the patient's problems. The treatment plan will include strategies to ready the patient and family for treatment, the specific pharmacological and psychosocial treatments necessary to address the various targets of treatment, the timing and sequencing of psychosocial and psychopharmacological interventions, and the strategies for monitoring outcome and side effects. Pharmacological treatments can be initiated before, concurrent with, or after psychosocial treatments, depending on the evidence base and needs of the patient.

Treatment with medication can be considered to have three phases: an acute phase, which includes the initiation of medication treatment and subsequent dose adjustments to maximize response and minimize side effects; the maintenance phase, during which responders to treatment consolidate their gains and remission or recovery occurs; and a discontinuation phase during which, if clinically indicated, medication is successfully tapered with minimal risk for relapse/recurrence.[57] The initial discussion of the treatment plan with the patient and family includes a discussion of the goals and approaches used in all phases of treatment.

At the beginning of the acute phase of treatment, psychosocial interventions to address patient and family factors that may impede the medication trial (e.g., inadequate supervision of medication adherence) or the assessment of outcome (e.g., parental lack of an understanding of target symptoms or common side effects) are initiated. Most clinicians will address this as part of the psychoeducation of the patient and family.

The plan for the medication trial is specific: starting dose, timing of dose changes, estimated maximum dose or blood level, strategies for monitoring and managing medication side effects, duration of the trial, assessment strategies (e.g., self-reports, parent reports, teacher reports), and alternative treatment strategies if the child is partially responsive or the trial is not successful. The AACAP practice parameters for specific disorders referenced above describe the detailed strategies for choosing a medication, starting doses and adjustment schedules, trial duration, and monitoring outcome and common side effects.

Traditionally, psychosocial treatment is recommended before pharmacological treatment. However, data are increasingly available from comparative treatment trials to guide the selection of first-line treatment. To date, randomized controlled trials suggest that medication management for ADHD is the first-line treatment[16] and that medication combined with behavioral treatment may be required for optimal outcome in children with more complex problems.[58] For OCD, beginning with cognitive-behavioral therapy, especially if delivered by expert psychotherapists, or combined treatment is the best first option.[46] In contrast, the Treatment of Adolescent Depression Study demonstrated efficacy for combination therapy and medication management but not for cognitive-behavioral therapy alone at 12 weeks, suggesting that beginning with psychotherapy only in moderate to severe depression may not be the best first step.[18]

Prescribers are guided by the evidence base in developing their treatment plan. However, the evidence base for pediatric psychopharmacology is far from complete[40] and may not be specifically applicable or adequate to maximizing outcome for the child. For example, when the severity of the child's problem is such that the disorder precludes active participation in targeted psychosocial treatment (e.g., OCD with psychotic symptoms), beginning with medication and supportive psychological treatment may be a reasonable approach. Also, although empirically supported psychosocial treatments may

be first line as in OCD, many communities lack skillful providers of such treatments. In these communities, starting treatment with medication may be the only evidenced-based intervention practically available.

At some point in the transition from the acute phase to the maintenance phase of treatment, the prescriber reviews the progress to date and discusses the plan for maintenance treatment. The discussion of maintenance treatment goals is often easier for patients and parents than the discussion of initiating treatment, as moving into the maintenance phase suggests that the patient has experienced some benefit and satisfactorily has passed through the period for acute side effects. The frequency of visits during the maintenance phase reflects the goals of maintaining response and adherence, reducing functional impairment, and monitoring for late-onset side effects (e.g., tardive dyskinesia) or side effects of accumulating significance (e.g., weight gain, slowed growth) and the development of co-occurring conditions.

If the patient has evidenced a sustained period of remission or recovery and the prescriber believes that the medication may no longer be necessary, a discontinuation trial may be clinically indicated. Before initiating a discontinuation trial, the plan for discontinuation is reviewed with the patient and family focusing on the risks of discontinuation (e.g., the risks for withdrawal symptoms and the risk for relapse or recurrence of symptoms) and the treatment plan if symptoms return. This is especially important if the patient was significantly impaired or suicidal before medication treatment. A specific plan for tapering and discontinuing medication and appropriate frequency of monitoring visits prevents withdrawal effects of medication and allows the clinician to identify early relapse/recurrence of symptoms. Monitoring children for a period of time after they are off medication allows for early identification of relapse/recurrence before symptoms become too severe.

The AACAP practice parameters, consensus guidelines, and treatment algorithms (e.g., Texas Medication Algorithm Project, *http://www.dshs.state.tx.us/mhprograms/TMAPover.shtm*) provide detailed information about treatment approaches to patients with various disorders at the various phases of treatment.

Principle 5. The Prescriber Develops a Plan to Monitor the Patient, Short and Long Term. Many factors are involved in determining a monitoring strategy for children on psychotropic medications including the type of medication, the risk for and timing of onset of side effects, the patient's need for ongoing psychological support, the patient's and family's risk for nonadherence, and the phase of treatment. Discussion of the monitoring plan with the patient and family includes the frequency of visits and methods used to assess outcome and side effects. The frequency of visits is determined by the need for dose titration, by the timing of onset of side effects, and to maintain the doctor–patient–family relationship. For example, medications that require multiple upward adjustments in dose may require more frequent visits initially than medications with fewer dosing adjustments. Monitoring medications with significant early-onset side effects (e.g., appetite suppression and insomnia on stimulants) would lead to more frequent early visits; monitoring for late-onset side effects (e.g., change in growth trajectory on stimulants) require at minimum the frequency of visits to ensure that side effects are detected. Follow-up visits are also an opportunity to provide psychosocial support, to address stressors and problems with adherence. Using rating scales in follow-up visits can be helpful to follow symptom severity; similarly, systematically documenting information on drug-specific side effects (e.g., weight gain, height, blood pressure) may be useful. The AACAP practice parameters for specific disorders (referenced above) offer guidelines on appropriate monitoring strategies. The clinician, patient, and family should develop an individualized monitoring plan appropriate to the needs of the patient and family and consistent with the prescriber's role in treatment.

During the maintenance phase, visits may not need to occur frequently. For example, children and adolescents with stable high-quality response and good adherence can be seen as infrequently as two to four times per year. Children and families under psychosocial stress or who have problems with adherence may need more frequent visits to maintain a high-quality outcome.

During the discontinuation phase, patients may actually need to be seen more frequently than during the maintenance phase. Close monitoring as the dose of medication is being lowered and, for a period of time thereafter, ensures that withdrawal symptoms and early signs of relapse/recurrence are identified quickly.

There are few data to help determine how long to monitor a child after the discontinuation of medication; however, the duration of follow-up reflects the risk for relapse in the short term and risk for recurrence of illness over the longer term. For example, in children with anxiety disorders, a monitoring period off medication of up to 6 months may be reasonable, given the time and financial burden of such follow-up and the low risk for relapse/recurrence for children who remain asymptomatic 6 to 12 months after treatment has been discontinued.[59] After discontinuation, visits may occur more frequently in the first few months and less frequently thereafter. It may be useful to schedule such follow-up visits before high-stress periods (e.g., the start of school for children with separation anxiety) or periods of known risk for recurrence (e.g., winter for seasonal affective disorder). For major depressive disorder and other disorders with a high risk for recurrence, it may be prudent to monitor children who

have discontinued medication at low frequency into adulthood.

Principle 6. Prescribers Should Be Cautious When Implementing a Treatment Plan That Cannot Be Appropriately Monitored. Implementing a pharmacological intervention requires extra caution in clinical situations in which there are barriers to monitoring the patient for outcomes and side effects. For example, a pharmacological trial is more challenging to implement when there is inadequate adult supervision, limited patient and family investment in treatment, or a high risk for nonadherence. Barriers to monitoring outcome and adherence increase the risk that the medication trial may be deemed unsuccessful or incomplete and increase the risk for inappropriate dosing, frequent medication switches, or the use of medication combinations. For example, if a prescriber is unaware that medications are not provided as planned, the prescriber may unknowingly increase the dose or add a second medication.

Assent and Consent for Treatment

Principle 7. The Prescriber Provides Feedback About the Diagnosis and Educates the Patient and Family Regarding the Child's Disorder and the Treatment and Monitoring Plan. After completing the evaluation and developing the treatment and monitoring plan, the prescriber educates the patient and the family about the child's problems, treatment options, and the treatment/monitoring plan. Such psychoeducation of the patient and family prepares them to assent and consent for treatment. The psychoeducation of the patient and family addresses the target of treatment, including the disorder's signs and symptoms; the course, including common complications (e.g., risk for oppositional behavior in children with ADHD) or potential for evolution of symptoms over time (e.g., recurrent depression may ultimately evolve into bipolar disorder); and the long-term prognosis (e.g., tic severity generally improves in late adolescence).[60] Specific risk factors (e.g., poor parenting skills) and protective factors (e.g., academic ability) that may affect the outcome of treatment also can be discussed. Negative attitudes about medication and the risk for adverse psychological reactions to taking medications in some children and their families are to be addressed directly.[61] The specifics of the medication treatment plan are provided: generic and trade name of the medication, starting dose, timing of dose changes, estimated peak dose or blood level, strategies for monitoring and managing medication side effects, duration of the trial, assessment strategies (e.g., self-report, parent report, teacher report), alternative treatment strategies, and the plan if the child does not respond as expected. Providing high-quality printed information from reliable sources about the proposed medication (e.g., U.S. Pharmacopoeia handouts) can be a useful adjunct to in-person psychoeducation.

To put the specific child's treatment plan into context, the prescriber discusses how his or her plan for the patient and family reflects the evidence base and relates to the usual care in the local community (i.e., the plan is more or less intensive than usual care or consists of medication management only or psychotherapy only). This information provides the patient and family an opportunity to evaluate the prescriber's plan vis-à-vis the evidence base and the practice pattern of other prescribers. Although the spectrum of clinical practice is broad, the prescriber should be familiar with the standard of care within his or her community and be able to communicate how he or she practices pharmacotherapy. As pharmacological treatment of childhood psychiatric disorders is increasingly a topic in the media, the prescriber's understanding of recent controversies (e.g., SSRIs and suicidality) and how they have an impact on treatment planning is critical to prescribing psychotropic medications to children.

Extended psychoeducation to address specific attitudinal or psychological issues regarding medication and/or specific psychosocial interventions to stabilize the home environment may be necessary to ready some patients and families to effectively implement or monitor a pharmacological treatment trial.[62] For example, some teenagers may see taking medication as making them only "different" but not "better." Similarly, some families may not understand their child's difficulties from a psychopharmacological point of view (e.g., "He doesn't need medication, he just won't listen."), have difficulty understanding how medication may be useful (e.g., "Aren't all teenagers moody?"), have too high (or too low) expectations for medication treatment, or worry excessively about side effects.

For the effective implementation of the trial, prescribers need to clarify who is responsible for the various elements of the treatment plan. The responsibility for some elements may fall to the family and some to other professionals involved with the child (e.g., teacher ratings during stimulant treatment). Parents are ultimately responsible for storing medication safely and monitoring medication adherence, benefits, and side effects. Empowering the child to identify and communicate benefits and problems with the medication trial is also important. Although there can be variability in how children and families choose to implement pharmacological treatment (e.g., older teens taking more responsibility for taking their medication), being clear with the patient and family regarding their specific roles and responsibilities in treatment and strategies for managing his or her medication may improve adherence and enhance outcome. The prescriber also needs to be clear with the family about his or her role in treatment. Some prescribers restrict their role to pharmacotherapy only, others will prescribe medication only

if they are also responsible for the psychotherapy, and some who can prescribe may restrict their practice to assessment/consultation or psychotherapy only. Patients and their families may not always understand that prescribers can delimit their role in these ways and may expect the prescriber to function more comprehensively. Clinicians who limit the range of interventions provided may unwittingly implement a treatment plan that does not address the complexity of the patient's problems. For example, it is possible that patients who receive medication management only may not have their psychosocial needs assessed or treated and run the risk for being given medications to address problems that might be better addressed through psychosocial interventions. Similarly, clinicians who only practice psychotherapy may not use medications when clinically appropriate.

Principle 8. Complete and Document the Assent of the Child and Consent of the Parents Before Initiating Medication Treatment and at Important Points During Treatment. Assent and consent is considered an ongoing process of relationship building with both the patient and the family that begins with the evaluation and continues after treatment has been initiated. A specific assent/consent discussion before initiating a new medication treatment provides an opportunity for the prescriber to summarize the findings from the assessment, for the prescriber to present the treatment/monitoring plan, and for the child and parent to have their questions and concerns addressed. The assent/consent procedure also provides the clinician an additional opportunity to assess what the patient and family understands of the child's problems and their readiness and commitment to participate in treatment. After treatment has begun, the prescriber continues to assess whether the family and patient truly understand the process in which they are involved and determines whether the family is providing ongoing assent/consent for the care they receive.

As assent/consent is an ongoing process; it is recommended that before initiation of any additional psychotropic medications, at the transition to the maintenance phase, and before a discontinuation trial, the prescriber, patient, and family review the rationale for treatment; the past treatment experience; and the benefits, risks, and alternative treatments for each additional medication or the next phase of treatment.

Prescribers should document in the patient's medical record the initial assent/consent procedure as well as ongoing assent/consent during treatment. The documentation does not have to be extensive, but it does need to reflect adequately what occurred in the discussion with the patient and family. It is also useful for the prescriber to document that the patient and family had an opportunity to ask questions and have them answered and that the family understood the nature of the target of treatment and the specific risks and benefits of treatment.

The duration of the assent/consent procedure will vary, depending in part on how well the prescriber has prepared the patient and family. Many of the issues to be addressed during assent/consent are part of the prescriber's psychoeducation of the patient and family. The assent and consent discussion for most patients and families can be completed in a single session.

Principle 9. The Assent and Consent Discussion Focuses on the Risks and Benefits of the Proposed and Alternative Treatments. The content of assent/consent discussion should meet the current ethical and medical-legal standards. As consent standards evolve over time, and are tailored to meet the needs of the patient and family, it is critical for prescribers to be aware of the standard of care in their specialty, their community, and more specifically what patients and families need to know to actively participate in the treatment. A variety of resources are available to clinicians about the standards for consent; however, most published information concerns informed consent for research. For more specific information about the consent standard for prescribers in clinical practice, a discussion with the prescriber's malpractice carrier may be helpful.

Basic information provided during assent/consent would include the target of treatment, that is, signs and symptoms present in a particular child; the potential for benefit and side effects; the risks of not treating with medication; the timing and method of assessing outcome and side effects; the time commitment for treatment and monitoring; a description of the usual care in the community, including treatment alternatives (e.g., both medication and psychosocial alternatives) and their respective benefits and risks; a clear expectation that the family and patient will participate actively in the trial; and what to do if problems develop in treatment or the child does not respond as expected.

The prescriber has the responsibility to place the benefits and risks of the medication trial into perspective for the patient and family. For example, it can be helpful for parents to understand that the goal of the acute phase of treatment is to know how well their child responds to a medication and that the vast majority of side effects encountered during the acute phase (e.g., stomachaches, sedation, insomnia) respond to dose reduction or discontinuation and have little lasting significance. If the child responds, then the parents have to decide whether to transition to the maintenance phase of treatment. Thus, at the end of a successful short-term trial, patients and parents are weighing the observed benefit of medication against the acute side effects and potential for any longer term risks of the medication. Reassuring patients and parents that the prescriber will discontinue medications that are not useful or have unacceptable side effects may increase patients' and parents' comfort with starting medication.

Although it is not possible to provide a full and complete description of all the potential benefits and risks of the

proposed treatment and alternative treatment options, patient and parents should understand that some children respond well to medication treatment, and some do not respond at all. Common and expectable risks of the medication as well as patient- and family-specific risks (e.g., the potential for added risk for antipsychotic-induced weight gain in a child with obesity and a family history of type II diabetes) are discussed. Adverse events that may have prognostic significance (e.g., switching to mania on antidepressants) are rare, but clinically important adverse events (e.g., development of suicidal ideation during the medication treatment of depression) are also discussed. It may also be useful to discuss with patients and families that unexpected, unique, and perhaps even life-threatening events may occur during the course of treatment that may or may not be related to medication (e.g., sudden unexpected cardiac death). Although general information about the medication plan are shared, issues of specific relevance to the patient and family are also discussed (e.g., alcohol use and unprotected sex during medication treatment for at-risk teenagers) and addressed (e.g., problems with pill swallowing in younger children and teenagers' concerns about taking medication at school or on overnight activities). As many families may learn about medication benefits and risks in the popular media, specifically addressing the controversies regarding the use of medication for childhood psychiatric disorders may be useful (e.g., suicidality associated with antidepressant use and the cardiac risks of stimulants). Much of the information discussed during assent/consent may not be retained by the patient and family, and periodic review of the goals of treatment, as well as risks and benefits of treatment, may be required.

Clinicians should confidently provide information regarding risks and benefits and then put the treatment recommendation into context: How important is it to consider medication? What is a reasonable time frame for patients and parents to deliberate? For example, in a child with excellent coping and mild to moderate depression, it may be advisable to attempt a trial of psychotherapy first[63] or to allow the family and patient more time to consider pharmacological treatment. On the other hand, it may not be appropriate for parents to delay pharmacological treatment of a depressed and suicidal teenager because of concerns regarding the risk for readily managed side effects. Emphasizing the benefits and minimizing the risks of pharmacological treatment to enhance the chance that the family and patient will agree to a medication trial is not consistent with good clinical care. The prescriber–patient relationship may be harmed, if the discussion of side effects is not detailed enough and significant adverse effects occur.

Prescribers are encouraged to have a similar discussion before adding additional medications and before the transition to maintenance and discontinuation phases.

Implementation of Treatment

Principle 10. Implement Medication Trials Using an Adequate Dose and for an Adequate Duration of Treatment. For most medications, there is a dose level of the medication (measured by milligrams per day, milligrams per kilogram per day, or blood level) and duration of the treatment trial (based on pace of upward adjustment and time frame for observing a response) that will qualify a medication trial as adequate. For example, stimulants can be dosed empirically or on milligrams per kilogram per dose or milligrams per kilogram per day basis. An older child may require larger doses and more upward dose adjustments than a younger and smaller child; therefore, the trial may take longer for older and larger children. Antidepressants do not work as quickly as stimulants and may require upward of 8 weeks of treatment on an optimal dose to identify a response (Child Medication Algorithm Project—MDD Tactics, *http://www.dshs.state.tx.us/mhprograms/mddpage.shtm*). Completing a trial of adequate dose and duration gives the child the best chance to be able to benefit from a single medication. The outcomes of medication trials that are not adequate in either dose or duration are difficult to interpret. Inadequate medication trials may increase the risk that children will not have the opportunity to benefit or put children at risk for multiple medication switches or medication combinations. For example, a child given too low a dose because of unrealistic concerns about side effects may fail to respond. Yet because the child was exposed to medication, the patient, family, and prescriber may consider the child a "nonresponder" and then treat the child with second-line medications or multiple medications.

Principle 11. The Prescriber Reassesses the Patient if the Child Does Not Respond to the Initial Medication Trial as Expected. A variety of factors can be involved in an unexpected lack of response to a medication trial: the original assessment was not accurate (e.g., comorbid disorders or psychosocial factors were unaccounted for or not addressed adequately), the family was not ready to implement and participate in the trial, the trial did not include an adequate dose or duration of medication treatment, or there was poor adherence. If the acute phase trial was adequate in dose, duration, and adherence, then a reassessment of the patient is appropriate. The reassessment can include a review of the original assessment and treatment plan, an actual psychiatric reassessment of the patient, or outside consultation.

Prescribers need to be particularly alert to mistaking behavioral and emotional reactions to psychosocial stressors as symptoms of an underlying biological illness. Such misattribution can occur not only during the initial evaluation but also during treatment. For example, children recovering from a major depressive disorder may have persistent academic and social disability and may become irritable when

facing academic or social challenges. If the irritability is part of the mood disorder, then medication treatments may be appropriate. If, however, the irritability is related to the challenge of getting back to the previous level of functioning after a significant depressive episode, then psychosocial interventions may be more useful. The problem of using medications to address "all" of a patient's symptoms is not isolated to prescribers. Other stakeholders in the child's life (e.g., parents, teachers) may also believe that fluctuations in "symptoms" need to be addressed by medication changes or additions. The prescriber who does not appreciate the need for combined psychosocial and psychopharmacological treatment for children with concomitant psychosocial problems (e.g., ADHD with oppositional defiant disorder[58]) may unnecessarily expose the child to increasingly complex pharmacological treatment strategies.

Principle 12. The Prescriber Needs a Clear Rationale for Using Medication Combinations. Before the use of medication combinations, the prescriber needs to develop a treatment and monitoring plan, educate the patient and family, obtain assent/consent, and then implement the treatment trial as described under the principles above.

Commonly used psychotropic medication combinations include the following: medication combinations used to treat multiple disorders in the same patient (e.g., a stimulant and an SSRI for ADHD and anxiety[41] or an antipsychotic and an SSRI for tics and OCD[43]), medication combinations that offer unique treatment advantages for a single disorder (e.g., the addition of lithium to ongoing antidepressant treatment[44]), and medication combinations to address side effects of an effective agent (e.g., benztropine for extrapyramidal symptoms secondary to an antipsychotic).

Although it is possible that combining medications from the same class may have empirical support in the future, there is limited support for such approaches at this time. For example, there is limited evidence in children and adolescents for the use of two antidepressants or two antipsychotics as an initial treatment approach or as a specific endpoint for treatment. However, it is not uncommon for patients to be taking two antidepressants or two antipsychotics at the same time when transitioning from one medication to another. For bipolar disorder in adults, data do support the use of two mood stabilizers,[64] and there is preliminary support for the use of similar strategies in children with bipolar disorder.[65] In addition, two stimulant formulations (i.e., short and long acting) may be used to "sculpt" dosing for coverage of extended periods of time.[13]

Evidence supporting medication combinations based on a matching medication mechanism of action with a hypothesized underlying central nervous system abnormality is rudimentary at best. For example, there is limited data to support the use of two antidepressants to cover two neurotransmitter systems (i.e., using a serotonergic and a noradrenergic antidepressant for a certain profile of depressive symptoms). Basing treatment decisions on theories about central nervous system functioning or clinical correlates of hypothesized neurotransmitter abnormalities (e.g., specific symptom profiles, EEG, single-photon emission computed tomography testing) may put patients at risk for unnecessary medication combinations "to cover the neurotransmitter bases" or "to treat the EEG or single-photon emission computed tomography results."

Principle 13. Discontinuing Medication in Children Requires a Specific Plan. More is known about starting children on medication than about how long to treat and how best to discontinue one or more medications in children. Discontinuing medications can occur for a variety of reasons: the patient seems to have recovered and may no longer need medication, the patient has developed side effects to the medication that make it untenable for the patient to continue to take the medication (e.g., weight gain, concerns about growth or the development of involuntary movements), or the patient may be taking a medication that the current prescriber does not feel is warranted or is considered to be no longer effective. A thoughtful and safe plan for medication discontinuation is as important as a thoughtful and safe plan for starting medications.

Before discontinuing any medication, prescribers are encouraged to obtain the history of previous psychiatric symptoms and response to medication. The history gathering can start with the patient and family; however, a review of medical records and discussion with the previous prescribers may also be useful. Although many patients can describe the symptoms of the disorder for which medication was given, not all patients and families are able to do so, and collateral history may be critical to making a decision to implement a discontinuation trial. Reviewing the history is especially important for the prescriber who believes that the current medication is not warranted or is no longer effective. Reviewing the history ensures that the patient will not be exposed to medication discontinuation that may result in a needless and unexpected return of symptoms.

Developing a monitoring plan for a discontinuation trial is also critical. Although it may take only hours to days to identify a return of hyperactivity symptoms in a child with ADHD off stimulants, a more extended period of monitoring may be required to determine whether patients with the inattentive subtype of ADHD are having a return of symptoms. Similarly, patients with mood and anxiety disorders may be able to have their medication tapered only to have a return of symptoms weeks to months after their last dose. Medication discontinuation in inpatient or partial hospital settings with short lengths of stay may be particularly problematic.

Discontinuation of effective medications in such settings may result in an unexpected and unmonitored return of symptoms after discharge.

Although some medications may not actually require gradual tapering, prescribers are generally encouraged to taper medication slowly to avoid withdrawal symptoms (e.g., benzodiazepines or SSRIs) or rebound worsening of symptoms (e.g., antipsychotics for tics or lithium for mania). Gradual tapering may also be prudent if it is unclear whether the current medication is having a beneficial effect.

At this time, there are little or no data to suggest which medication to remove first in children who are taking multiple medications. Given the lack of data, the examples follow general clinical reasoning. If a child is taking two medications that target the same disorder, the first medication to be removed would likely be the medication that was used adjunctively or as an augmenter. For example, in children with OCD treated first with clomipramine and later with a benzodiazepine or antipsychotic to further reduce anxiety, it would be reasonable to reduce and eliminate the benzodiazepine or antipsychotic first. Similarly, in a child with depression who had a partial response to antidepressants and then achieved remission with lithium augmentation, removing the lithium may be the most appropriate first step. A corollary to this approach is to keep the medication with the most prophylactic efficacy or the one with the least long-term side effect potential. For example, a teenager with bipolar disorder may have derived equivalent benefit from an antipsychotic and lithium. Given the relative long-term safety profile and prophylactic effects of these medications, the antipsychotic might be tapered first.

If a child is on two medications, one for the underlying disorder and the second to manage side effects of the first, it is likely that the first to be removed is the one used to manage side effects. For example, if an anticholinergic medication is added to an antipsychotic to reduce the risk for extrapyramidal symptoms during initial treatment, it may be possible to discontinue anticholinergic medication after the child is stabilized on the antipsychotic. However, if the child requires anticholinergic medication for the ongoing management of extrapyramidal symptoms, it would be prudent to maintain the anticholinergic medication well after the antipsychotic is discontinued to prevent the delayed emergence of extrapyramidal symptoms.

If a child is on two medications for two disorders, the first medication to be removed is for the disorder that is more likely to go into remission or which is less severe or impairing. For example, for a child taking stimulants and antidepressants for ADHD and depression who has been stable without depressive symptoms for an extended period, it would be reasonable to consider tapering the antidepressant first, or if the ADHD was mild and never impairing until the child became depressed, it might be more appropriate to discontinue the stimulant first.

In all of the above cases, the role of the underlying and most severe condition and the sequence and rationale for which medications were combined contribute to the plan for discontinuation of multiple medications in children.

PARAMETER LIMITATIONS

The AACAP practice parameters are developed to assist clinicians in psychiatric decision making. These parameters are not intended to define the standard of care, nor should they be deemed inclusive of all proper methods of care or exclusive of other methods of care directed at obtaining the desired results. The ultimate judgment regarding the care of a particular patient must be made by the clinician in light of all of the circumstances presented by the patient and his or her family, the diagnostic and treatment options available, and available resources.

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