Georgia Psychotropic Medication Monitoring Project

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Executive Summary
The proliferation of psychotropic medication use for the treatment of mental and behavioral health disorders among children in foster care has captured the attention of clinical researchers, child welfare professionals, state and national policymakers, and the public at large. Recent studies consistently document higher rates of utilization in the foster care population than are seen in the overall youth population and comparable populations of Medicaid-eligible youth. Polypharmacy is also more common among children in foster care, particularly combinations involving antipsychotic medications. These trends are disturbing because the safety and effectiveness of many of these medications has not been established, particularly for use with children. Additionally, these medications are costly to state Medicaid programs.

In collaboration with Casey Family Programs, the Barton Child Law and Policy Center and Child Welfare Collaborative led a year-long project to examine the state’s capacity for oversight of the administration of psychotropic medications to children in foster care. The Georgia Psychotropic Medication Monitoring Project included comprehensive medical and legal research; review of agency policies; clinical review of select foster care cases and consultation by an independent child psychiatrist; and training for caseworkers, foster parents, attorneys, judges, and Court Appointed Special Advocates. Its aim was to facilitate the state’s compliance with federal mandates requiring increased oversight and specific protocols for the administration of psychotropic medications to children in foster care.

Review and analysis of Medicaid claims data indicates that Georgia exceeds the national averages for use of psychotropic medications and antipsychotic medications, in particular, in the state’s foster care population. File reviews of 93 cases of children experiencing extended stays in foster care revealed concerning trends in prescribing practices, including frequent polypharmacy, sometimes used for behavioral control of children. Deficiencies were noted in casework practices for obtaining and documenting informed consent, in part due to the failure of agency policies to clearly identify who is authorized to give informed consent and to address overreliance on blanket authorizations. Furthermore, child welfare policies and practices overlook the importance of obtaining the child’s assent to treatment. The state also lacks the infrastructure and recommended features of a formal oversight system, including a consultation program to connect child welfare personnel and clinicians with expertise; protocols for routine coordination, data-sharing and reporting between the state’s child welfare, mental health and Medicaid agencies; and training for caseworkers, court personnel, foster parents and other system stakeholders.

Because of their powerful treatment effects and budgetary impact, administration of these medications deserves closer scrutiny, especially when prescribed for youth in foster care. Toward that end, the Georgia Project presents the following recommendations for systemic oversight of psychotropic medication use among children in foster care:
1) DHS-DFCS policy should clearly identify who is authorized to provide informed consent to medication treatment for a child in foster care (caseworker, administrator, parent/guardian, foster parent, etc.) and outline the responsibilities of that role;

2) DHS-DFCS should develop clear practice guidance and/or policy to facilitate consistent and meaningful engagement of the biological parent(s) in the course of the child’s treatment, including how the agency should respond to parental requests for changes in treatment;

3) DHS-DFCS should develop clear practice guidance and/or policy to facilitate consistent and meaningful engagement of the child or youth, including procedures for obtaining the youth’s assent to the recommended treatment;

4) DHS-DFCS should adopt a standardized written consent form to facilitate proper, individualized treatment for every child in foster care who needs mental or behavioral health interventions; alternatively, DFCS should coordinate efforts with DBHDD to develop and consistently employ a provider-specific consent form;

5) DHS-DFCS should implement quality assessment measures to ensure proper documentation of the agency or parent’s informed consent and the child’s assent in the case record, including current and complete information entered into the Health Log pages in SHINES;

6) DHS-DFCS should actively explore expanded adoption of an electronic health record / medical passport model, beginning with existing capacity in SHINES;

7) DHS-DFCS should develop explicit protocols for sharing individual case-level information (maintained electronically or in paper form) with treatment providers, foster parents or other caregivers, the child’s attorney or guardian ad litem, and the court, as needed to ensure coordinated care;

8) DHS-DFCS should adopt an express prohibition in policy against the use of psychotropic medications as chemical restraints and for purposes of punishment or convenience of the caregiver, staff, or parent;

9) DHS-DFCS should adopt an express prohibition in policy against the use of as-needed/blanket/pro re nata authorizations;

10) DHS-DFCS, in partnership with DBHDD and DCH, should develop a training curriculum and educational opportunities for agency personnel and system stakeholders (foster parents, judges, attorneys, Court Appointed Special Advocates) to improve understanding of the mental and behavioral health needs of children in foster care, available medication treatments, and nonpharmacological alternatives to medication;

11) DHS-DFCS should coordinate with its sister agencies DBHDD and DCH to promote awareness of and adherence to the DBHDD medication utilization standards among clinicians treating children in foster care through strengthened contract
standards or other quality assurance mechanisms;

12) DHS-DFCS, DBHDD, and DCH should develop a process for review of cases that fall outside of the medication utilization parameters that includes a “second opinion” capacity involving comprehensive record review by a qualified professional and face-to-face evaluation of children when needed or upon request;

13) DHS-DFCS should partner with its sister agencies DBHDD and DCH to develop a coordinated response to foster care providers/mental health service contractors identified for problematic prescribing patterns;

14) DHS-DFCS should partner with its sister agencies DBHDD and DCH to build service capacity among providers offering evidence-based therapies as alternatives or compliments to medication treatments;

15) DHS-DFCS should develop a consultation program under the direction of the new Medical Director to provide expertise to caseworkers and prescribing physicians;

16) DBHDD should consider the technical revisions to its medication utilization parameters suggested by the clinician workgroup convened as part of the Georgia Project;

17) DCH should continue monitoring the impact of its prior authorization program and make results available through periodic public reporting;

18) DCH should continue to solicit clinician and consumer input concerning any modifications to its prior authorization program;

19) DHS-DFCS, DBHDD, and DCH should establish inter-agency monitoring and information-sharing protocols regarding case-level and aggregate utilization trends (rate and type), adverse events, and outlying prescribers and share relevant detail with providers, caseworkers and administrators, child welfare system stakeholders and the public;

20) DHS-DFCS, DBHDD, and DCH should centralize relevant policies, procedures, and educational materials on a publicly-accessible website.
The Georgia Psychotropic Medication Monitoring Project

*Final Report and Recommendations*
PROJECT BACKGROUND

Concerns about the prevalence of psychotropic medication use among children and youth in foster care are well-documented. Psychotropic medications are used to affect psychological functioning, perception, behavior, or mood, and they are commonly used to treat the serious emotional and behavioral health disorders of children in foster care. Research in this area has been driven by the observed increase in the utilization of psychotropic medications, and related pharmaceutical expense, among the general population and particularly in the foster care subpopulation. Expanding state Medicaid budgets and documented deficiencies in states’ abilities to achieve positive health outcomes for children in foster care are fueling state and national attention to the need for stronger systemic oversight and improved case-level outcomes. Congressional mandates incorporated in the Fostering Connections to Success and Increasing Adoptions Act and the recently-enacted Child and Family Services Improvement and Innovation Act call upon states to pay specific attention to and adopt protocols for the administration of psychotropic medications. Most recently, the U.S. Government Accountability Office (GAO) released a report recommending that the federal Secretary of Health and Human Services (HHS) consider issuing HHS-endorsed guidance to states on best practices for monitoring psychotropic drug prescriptions for children in foster care. A growing library of medical, administrative, and legal resources exists, and common themes are emerging to guide state approaches.

Additionally, further guidance aimed to reduce variability in state policies and practices is expected from the federal government. As one indication, a joint letter to state child welfare

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3 See Fostering Connections to Success and Increasing Adoptions Act of 2008, Pub. L. No. 110-351 (requiring states to expand access to medical homes and improve oversight of prescription medications); Child and Family Services Improvement and Innovation Act, Pub. L. 112-34 (2011) (requiring states to include in their five-year state plans details about how emotional trauma associated with maltreatment and removal is addressed and a description of how the use of psychotropic medications is monitored).


agency directors issued by the federal Administration for Children and Families, the Centers for Medicare and Medicaid Services and the Substance Abuse and Mental Health Services Administration pledges opportunities including a convening of state directors of child welfare, Medicaid, and mental health authorities to develop action plans addressing how to strengthen systems of prescribing and monitoring psychotropic medication use among children in foster care.\(^6\) Because the attention of the federal government is trained on state child welfare systems, many of the recommendations contained herein are directed to the attention of the Department of Human Services and its Division of Family and Children Services (DHS-DFCS). 

Successful outcomes for youth in foster care, however, will only be fully realized upon the joint and coordinated efforts of DHS-DFCS and its sister agencies: the Department of Behavioral Health and Developmental Disabilities (DBHDD) and the Department of Community Health (DCH). Mental health outcomes for abused and neglected children in the state of Georgia are the shared responsibility of all these agencies as the DHS-DFCS serves as the legal guardian for children in foster care, the DBHDD contracts with mental health service providers, and the DCH functions as the medical insurer. This is a complex issue, and therefore, a multi-system response is required.

In collaboration with Casey Family Programs and with support from the DHS-DFCS and the non-profit Child Welfare Collaborative, the Barton Child Law and Policy Center led a year-long project to explore concerns regarding the administration of psychotropic medication use among children in Georgia’s foster care system. The project was designed to better understand the prevalence of psychotropic medication use in Georgia’s foster care population, examine the existing policy and practice landscape for oversight, and make recommendations for improvement. The Georgia Psychotropic Medication Monitoring Project (“Georgia Project”) began in February 2011 and ended January 2012. Building on previous work in Georgia,\(^7\) its components included comprehensive policy and legal research and review of medical literature, training of DHS-DFCS employees and a cross-section of child welfare system stakeholders, limited clinical review of referred foster care cases and consultation by an independent child psychiatrist, and collaborative review of medication utilization parameters, which guide prescribing patterns.

This report presents the findings from the Georgia Project and recommendations for improvement along the frameworks proposed by national studies. It is intended to facilitate the continued progress of the state toward compliance with the requirements of federal law and most importantly, toward the realization of positive outcomes for children in Georgia’s

\(^6\) See \textit{Joint Letter to State Child Welfare Directors}, supra note 5.

\(^7\) Karen Worthington, \textit{Psychotropic Meds for Georgia Youth in Foster Care: Who Decides?} Published by the Georgia Supreme Court Committee on Justice for Children, November 2010.
foster care system. The progress the state, its agencies, and its professionals have made during the course of the Georgia Project is commendable. Early efforts have well-positioned Georgia to provide national leadership on improvements in practices and policies related to oversight of the administration of psychotropic medications in foster care.

INTRODUCTION

Georgia’s Psychotropic Medication Monitoring Project began with the troubling case of one teenager in foster care. The 14 year-old boy had attracted the state’s attention after being identified through the Cold Case Project, an innovative court-agency venture designed to identify and remove legal barriers to permanency for youth at risk of aging out of foster care. His case profile was featured in an editorial authored by State Representative Mary Margaret Oliver published in the Atlanta Journal Constitution on November 18, 2010.8

Tragedy struck “Tommy”9 early, permanently altering the course of his family and his life. When he was just seven, Tommy was the oldest of six children between the ages of four months and seven years left home alone, during which time his two year-old half-sister drowned in the bathtub. Tommy’s parents were arrested, and Tommy and his brother were placed in foster care. After being released from jail, Tommy’s parents reclaimed custody of Tommy’s sibling and left Georgia. Tommy was left behind, abandoned to the permanent custody of the state. His many years in foster care have been interrupted by multiple admissions to state mental health hospitals. He is presently living in a highly-structured facility for children with serious to severe emotional and behavioral management issues, and his prognosis for living within a family setting is guarded.

Though Tommy’s assessment at the time of his removal was of a “pleasant, enjoyable, and active 7-year old” who was protective and nurturing toward his brother, the difficult memories of his sister’s death and his disrupted attachments have affected him. Over his years in foster care, Tommy had acquired and was receiving mental health treatment for multiple Axis I diagnoses, for which he was ingesting nineteen (19) doses of seven different psychotropic medications daily to manage his emotions and behaviors. The effects of this heavy medication load were significant, including the involuntary movement symptoms associated with tardive dyskinesia. Yet he still expressed hope and desire for a family. That quest to achieve permanency for Tommy marked the beginning of Georgia’s inquiry into its child welfare medication practices.

9 Pseudonym given to protect privacy and confidentiality. All factual references are made on the basis of case records on file with the authors.
As part of the Georgia Project, Tommy was referred to an independently contracted child psychiatrist for a medical evaluation to assess current diagnoses, recommended treatment, and prognoses for permanency. The independent psychiatrist questioned the bases for ongoing medication treatment of several diagnoses that had likely not been revisited once labeled, documented multiple prescriptions targeting the same cognitive and behavioral difficulties (specifically three antipsychotic medications administered simultaneously), and noted the steady addition of new medications and/or dosage increases seemingly without efforts to taper, discontinue or otherwise adjust the existing medication burden. During his interview, Tommy was able to name most of his medications, but he was not aware of the indications for his medication or his current diagnoses. Additionally, he expressed concern about the amount of medication he was taking. Informed consent was not available in the records provided, and the laboratory monitoring recommended for the medications was likewise not well documented.

Though he presented with unique and serious challenges, Tommy nevertheless deserves a family, and the state is responsible for finding him one. As a result of the independent review and consultation, Tommy was weaned from many of his medications slowly over several months. As his functioning was restored, Tommy experienced greater personal and interpersonal successes, allowing him to gain freedom and privileges as he moved up in the group home "level system." He reported feeling hope and optimism for the future, including finding a place within a family.

Cases like Tommy’s can be found in every state. Dedicated caseworkers, foster parents, attorneys, judges, agency administrators and policymakers are eager for solutions to the frustration and helplessness they feel when trying to do right by a child, like Tommy. The state-as-parent has a legal and moral duty to ensure safety, achieve permanency, and fulfill the well-being needs of every child in foster care. Psychotropic medications can be an effective tool to stabilize and ameliorate certain mental or behavioral health symptoms. However, disturbing trends suggest that for many children in foster care, these medications are not being used appropriately as an integrated part of a strategic and comprehensive mental health treatment plan. The expediency of psychotropic medications permits over- and improper medication and warrants increased oversight for this vulnerable population.
UTILIZATION OF PSYCHOTROPIC MEDICATION IN FOSTER CARE

Studies consistently reveal a high foster care-specific prevalence of psychotropic medication. A recent study of the policies and practices of 47 states and the District of Columbia regarding psychotropic medication use for treatment of behavioral and mental health problems of children in foster care found much higher rates of psychotropic medication use in foster care than for the general youth population. Estimated rates of utilization in the foster care population ranged from 13-52% as compared with 4% in the general youth population. Increased utilization is a product of many interrelated factors including scientific advances, policy incentives, and market forces. New drug classes introduced in the last 15 years have expanded treatment options, and their clinical advantages have increased degrees of patient comfort and demand. Also, direct-to-consumer marketing, which has been found to influence therapeutic choice, began in the mid-1990s.

Of concern, clinical research on the use of these medications in children is largely lacking and consequently, few have Federal Drug Administration (FDA) indications for safe and efficacious use alone or, especially, in combination with other medications. In the absence of empirical support, clinicians are left to adapt adult protocols for children, experiment with efficacy, and make assumptions about overall safety. Additionally, some psychotropic medications being used in children do not have an FDA indication for use in mentally ill adults or children. A related consequence has been the emergence of significant variability with respect to policies and practices on the use of psychotropic medication in pediatric patients, particularly those in foster care. Thus, reported trends in prescribing patterns do not reveal much about underlying

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10 E.g., Prescription Psychotropic Drug Use Among Children in Foster Care, Hearing before the Subcommittee on Income Security and Family Support of the Committee on Ways and Means, 110th Congress (May 8, 2008), testimony of Julie M. Zito, Ph.D.
11 Multi-State Study, supra note 1, at 1.
12 Id.
13 See Richard G. Frank, Rena M. Conti, & Howard H. Goldman, Mental Health Policy and Psychotropic Drugs, THE MILBANK QUARTERLY, Vol. 83, No. 2 (2005) (reporting that from 1988 to 2003, two major new classes of psychotropic medication were introduced, and nine new antidepressant medications and five new antipsychotic drugs were approved by the U.S. Food and Drug Administration, and these newer generation of drugs tend to be safer, better tolerated by patients and easier for clinicians to prescribe because they offer simpler dosing schemes).
16 See Michael W. Naylor, et al., Psychotropic Medication Management for Youth in State Care: Consent, Oversight, and Policy Considerations, CHILD WELFARE, Vol. 86, No. 5 (2007) (asserting that a review of the 2006 Physicians’ Desk Reference showed that only 31% of psychotropic medications were approved for use by patients under age 18).
clinical judgment or the appropriate role of medication in treatment. Consensus does exist, however, on two points: first, that medication can be a valuable tool in treating mental and behavioral health issues, and secondly, that medication alone or in excess is rarely an appropriate intervention.17

Though trend data for the state is not available, psychotropic utilization rates in Georgia’s foster care system appear high.18 According to fiscal year 2010 Medicaid claims data collected by DCH, 32.5% of children in foster care who were continuously enrolled in the state Medicaid program were prescribed at least one psychotropic medication, and almost 5% were prescribed at least four (4) different psychotropic medications.19 Furthermore, slightly more than one in three children in foster care receiving psychotropic medication was prescribed at least one antipsychotic medication.20 The prevalence of psychotropic and antipsychotic medication use is important to note because of the significant, long-term, and sometimes irreversible side effects that accompany these medications as well as the enormous cost burden to state Medicaid systems.

Because children in foster care are in the custody of the state, they receive prescription medications and other services through Medicaid. The five states examined by the GAO spent over $375 million for prescriptions provided through fee-for-service programs provided to all children, both those in foster care and not in foster care.21 The Georgia DCH data shows that the net payment for psychotropic drug prescriptions for children in Georgia’s foster care system exceeded $13 million in fiscal year 2010.22

UNIQUE PROFILE OF CHILDREN IN FOSTER CARE
Children in foster care present unique treatment challenges that exacerbate the risk of being improperly medicated. Children in foster care have disproportionate mental health needs, often of greater complexity than the general youth population because of their early childhood exposure to violence, abuse or neglect. As explanation for the higher rates of psychotropic drug prescriptions in five selected states, the GAO attributes this utilization, in part, to foster children’s greater mental health needs, greater exposure to traumatic experiences and the

18 Georgia DCH, Georgia DHS, and the author acknowledge discrepancies in the data published in this preliminary report; however, it is the only available representation of psychotropic medication utilization in the state’s foster care population and provides an instructive baseline for continued discussions of data integrity across agency processes.
20 Id., emphasis added.
21 GAO REPORT, supra note 4.
22 DCH REPORT, supra note 18 at 6.
unique challenges of coordinating their medical care.\textsuperscript{23} Research and clinical experience support that conclusion, though neither illness severity nor system fracture justifies the potential health risks associated with high-risk medication practices.

\textit{Illness Severity and Prevalence}

An extensive body of research confirms that children in foster care have more significant mental health needs than do children in the general population.\textsuperscript{24} Children in foster care are at extremely high risk for emotional and behavioral disturbances, arising from the initial trauma of abuse or neglect and compounded by the experience of family disorder, disrupted attachments and loss of support.\textsuperscript{25} Accordingly, children and adolescents in foster care use mental health services at higher rates than other Medicaid-eligible youth.\textsuperscript{26} These findings suggest greater illness severity among this population, though other factors are also at play.\textsuperscript{27} Likewise, the disproportionate service need presents a greater vulnerability to inadequate mental health treatment delivered in a fractured public health care system. Where psychotropic medications are concerned, research clearly demonstrates that youth in foster care are more likely to receive complex and costly medication regimens that are not supported by empirical evidence of clinical efficacy.

According to the state’s most recent federal data submission, 64% of 12-15 year olds in Georgia’s foster care system are categorized as emotionally disturbed.\textsuperscript{28} An additional 69% of

\textsuperscript{23} GAO REPORT, supra note 4 (finding that foster children in Florida, Massachusetts, Michigan, Oregon, and Texas were prescribed psychotropic drugs at rates 2.7 to 4.5 times higher than were nonfoster children in Medicaid in 2008).

\textsuperscript{24} See B.J. Burns, et al., \textit{Mental Health Need and Access to Mental Health Services by Youths Involved with Child Welfare: A National Survey}, J. AM. ACAD. CHILD \& ADOL. PSYCHIATRY, Vol. 43, No. 8 (2004) (reporting approximately one-half of youth who enter the child welfare system have some emotional or behavioral problem, but only 55% receive mental health services that align with national standards). See also Ramesh Raghavan et al., \textit{A Preliminary Analysis of the Receipt of Mental Health Services Consistent with National Standards Among Children in the Child welfare system}, AM. J. PUBLIC HEALTH, Vol. 100, No. 4 (2010).

\textsuperscript{25} See generally Mark D. Simms, Howard Dubowitz and Moira A. Szilagyi, \textit{Health Care Needs of Children in the Foster Care System}, Pediatrics, Vol. 106 (2000). See also Julie M. Zito, et al., \textit{Psychotropic Medication Patterns Among Youth in Foster Care}, Pediatrics, vol. 121 (2007) (concluding that youth in foster care, as a group, have substantially more psychiatric disorders than their peers and that most disorders are behavioral in type).


\textsuperscript{27} See Erik Parens & Josephine Johnston, \textit{Understanding the Agreements and Controversies Surrounding Childhood Psychopharmacology}, Child and Adol Psychiatry and Mental Health (2008) (discussing the role of genetics, societal values, screening sensitivity, the expediency and cost-effectiveness of medication, and the limitations of diagnostic criteria in identifying and treating mental illness).

\textsuperscript{28} Adoption and Foster Care Analysis and Reporting System (AFCARS) data period from October 2010 through September 2011, \textit{FOSTERING COURT IMPROVEMENT} (Jan. 3, 2012, 4:42 PM), \url{http://www.fosteringcourtimprovement.org/ga/}.
youth 16 years of age and older are classified as such.29 “Child behavior” is identified as the reason for removal, alone or in combination with other documented reasons, for 24% of 12-15 year-olds and 31% of 16-17 year-olds in foster care, which may also signal underlying mental and behavioral health challenges.30 These children frequently acquire multiple behavioral and mental health diagnoses, as confirmed by Georgia’s Cold Case Project, a collaborative court-agency venture designed to improve long-term outcomes for youth at risk of aging out of foster care.31 The Cold Case Project was launched by the Supreme Court of Georgia’s Committee on Justice for Children in partnership with the Georgia Division of Family and Children Services (DFCS) in 2009.32 Of the 214 cases reviewed in the project’s first year, Cold Case attorneys documented ongoing or profound trauma experienced by 81% of the children whose cases were selected for review.33 About half (51%) had multiple DSM-IV Axis I disorders or both Axis I and Axis II disorders.34 Nineteen percent (19%) had chronic, serious, treatment-resistant mental illness and/or cognitive deficiencies, often necessitating long-term stabilization and treatment in an inpatient setting.35 Behavior management issues were also prevalent, with 34% of the children exhibiting behavior that was problematic in multiple settings, including physical violence and serious criminality.36 Another 16% of children exhibited behavior that was unmanageable in all but secure settings.37 These children often spend considerable time in therapeutic settings and institutions, which is confirmed by the state’s federal child welfare data profile.38 The Cold Case Project concluded with recommendations including, in relevant part, regular review of mental health treatment by an independent psychiatrist.39

**Diagnostic Challenges**

Due to their past trauma, children in foster care may exhibit symptoms that do not clearly fit within a diagnostic category; therefore, they may receive multiple diagnoses that change with

29 Id.
30 Id.
31 The Cold Case Project (2009-2010) was designed to examine cases of children who had been in foster care for more than two years with no connections to family and no identified prospects for a permanent home outside DFCS custody. The goal was to learn from these cases to improve permanency outcomes for all children in Georgia’s foster care system. See http://w2.georgiacourts.org/cj4c/index.php?option=com_content&view=article&id=73&Itemid=67 for more information and the full project report.
32 Id.
33 Id.
34 Id.
35 Id.
36 Id.
37 Id.
38 See generally AFCARS data, supra note 27.
39 Cold Case Project Summary, supra note 30.
time, placement setting, and medical provider. The research studies surveyed indicate that children in foster care are diagnosed more frequently with depressive disorders, anxiety disorders, Attention Deficit Hyperactivity Disorder (ADHD), conduct disorder, bipolar disorder, and oppositional defiant disorder, at rates greater than children with disabilities and comparable Medicaid-eligible children. Similarly, the Georgia DCH report places bipolar disorder and depression among the top diagnosis-based conditions for patients prescribed psychotropic medications. Because case records for the 93 children referred through the Georgia Project for independent psychiatric consultation were incomplete, a quantitative analysis of the frequency of diagnoses in the project sample is not possible. However, the diagnostic information that was available indicated that diagnoses of bipolar disorder, ADHD, conduct disorder, oppositional defiant disorder, post-traumatic stress disorder (PTSD), and/or depressive disorders were common.

Interestingly, the psychotropic medications used to treat these disorders are among those most commonly prescribed for children. However, their use in clinical practice has far outpaced the available data on safety and efficacy. As some indication of the prevalence of use in the foster care system, one study of youth in Connecticut’s Medicaid managed care program found that the status of being in state custody was the single strongest predictor of psychotropic drug use.

Severe emotional and behavioral dysregulation that manifests as a result of serious and persistent trauma is a confounding factor when diagnosing and treating mental illness in children in foster care. Many children in foster care are diagnosed with ADHD, bipolar

40 Julie M. Zito, et al., Psychotropic Medication Patterns Among Youth In Foster Care, PEDIATRICS, Vol. 121 (2008) (claiming that emphasizing symptoms and their persistence rather than a more comprehensive approach that accounts for severity and functional status has resulted in an increasing trend in comorbid conditions). See also Understanding the Agreements and Controversies, supra note 26 (discussing the advantages of a dimensional approach to diagnosis rather than the descriptive and categorical approach adopted by the DSM).
42 DCH REPORT, supra note 18. The Medicaid claims data on which this finding is based is inclusive of all Medicaid patients in the given year; claims specific to children in foster care are not able to be separated out.
43 Diagnoses were recorded in DFCS’ electronic case management database in only 28 of 93 cases.
44 Mark A. Riddle, Elizabeth A. Kastelic, & Emily Frosch, Pediatric Psychopharmacology, J. OF CHILD PSYCHOLOGY AND PSYCHIATRY, Vol. 42, No. 1 (2001).
45 Id.
disorder, or other disruptive behavior disorders when their behaviors, mood shifts, or difficulty sustaining attention may be better explained by their previous traumatic experiences. Diagnostic clarity is essential prior to the initiation of psychotropic medication and agreement should be reached among the patient, guardian, and provider that symptoms resembling behavior disorders (e.g. oppositional defiant disorder) or serious mood disorders (e.g., bipolar disorder) are not better explained by intrusive traumatic memories. In one study of privately-insured children, researchers confirmed that a diagnosis of bipolar disorder is often given to youth with complex constellations of psychiatric symptoms to justify medication treatments rather than making a diagnosis based on treatment response. Accordingly, medication treatments are added rather than substituted. Unlike children in foster care, however, those diagnoses given to privately-insured youth treated for mental disorders were subsequently reconsidered. Revisiting a diagnosis, particularly when new symptom patterns emerge, provides a critical opportunity to consider psychosocial interventions as an alternative to, or in combination with, medication therapies. Psychosocial and environmental approaches are sometimes preferable because of their net effect on the developing child. Though these non-pharmacological treatments are recommended as part of a comprehensive treatment plan, they may not be reimbursed adequately by Medicaid and often require more consistency to implement than the foster care system provides.

System Fragmentation
The state has a duty to ensure that children in foster care receive adequate health care to address their individual needs, no matter how complex. Ironically, in many ways the inherent nature of foster care undermines the ability of the child welfare system to fulfill this duty and contributes to the reliance on pharmacological treatments.

suggesting perhaps that it is the emotional distress consequent to abuse that predicts medication use, not abuse history per se).

48 Mark Olfson, et al., Mental Health Treatment Received by Youths in the Year Before and After a New Diagnosis of Bipolar Disorder, PEDIATRIC SERVICES, Vol. 60, No. 8 (2009) (identifying a service pattern suggesting that a diagnosis of bipolar disorder is often given tentatively to youth who exhibit symptoms such as impulsivity, hyperactivity, irritability, aggression, and school failure, which are also common to disruptive behavior disorders).

49 Id.

50 Id.

51 See Understanding the Agreements and Controversies, supra note 23 (asserting a parental preference for non-pharmacological treatments but recognizing that parents may nevertheless choose drugs because they are considered significantly cheaper and easier to administer).

52 Common barriers to coordinated treatment include: frequent and multiple placement changes to various settings, including psychiatric hospitals, residential treatment centers, juvenile detention facilities, and outpatient clinics; poor communication between providers resulting in fragmented psychiatric care; and high turnover of child welfare caseworkers.
As recognized by the American Academy of Child and Adolescent Psychiatry (AACAP), “[U]nlike mentally ill children from intact families, these children often have no consistent interested party to provide informed consent for their treatment, to coordinate treatment planning and clinical care, or to provide longitudinal oversight of their treatment.”

Rather, the sharing of legal and caretaking duties between foster parents, group home staff, treatment providers, attorneys, judges, Court Appointed Special Advocates (CASAs), the assigned caseworker and agency administrators, diffuses responsibility and exacerbates the fragmentation of medical and psychiatric care. The common experience of foster care, including multiple and frequent placement changes, overreliance on emergency room care, lack of proper psychiatric assessment and reassessment, and gaps in the system of care, make longitudinal coordination of health care difficult. As one example, Georgia’s placement stability rate is only 50% for children age 12-15 in foster care, and declines to 39% for children 16 years and older.

As one consequence of this instability, children in foster care often do not receive the treatment indicated for their diagnoses. A 2005 examination of Georgia’s child welfare practices undertaken by the HHS Office of Inspector General (OIG), reported four children in a sample of 50 cases who failed to receive necessary treatment despite the record containing an assessment indicating a need for mental health services. Furthermore, the OIG report identified eight children out of 23 sampled Georgia foster care cases who did not receive policy-mandated psychological evaluations within the required 30-day timeframe, with receipt ranging from 41 to 461 days after referral. A more rigorous review of Georgia’s child welfare system performance found persistent challenges to the state’s efforts to ensure that children receive adequate mental health services; in both the 2001 and 2007 rounds of the Child and Family Services Review (CFSR), the state’s failure to meet federal standards was attributed to its inconsistency in conducting assessments and a shortage of needed mental health services.

Inaccurate record-keeping and inconsistent sharing of medical information is a constant challenge to improvement efforts. The Adoption and Safe Families Act of 1997 establishes that the health and safety of children in foster care be considered of paramount concern. To that

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53 AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY, POSITION STATEMENT ON OVERSIGHT OF PSYCHOTROPIC MEDICATION USE FOR CHILDREN IN STATE CUSTODY: A BEST PRINCIPLES GUIDELINE (2005), http://www.aacap.org/cs/new_psychiatric_medications/psychiatric_medications.

54 Placement stability is defined as two or fewer moves in a 6 month period. AFCARS data, supra note 27.


56 Id. For policy mandate, see DFCS Foster Care Services Manual 1011.5, last updated 2004, available at http://www.odis.dhr.state.ga.us.


end, the federal law imposes specific practice mandates to facilitate the state’s fulfillment of its legal duty to provide safe and proper care for each child in state custody. Pursuant to those mandates, an individualized case plan for each child in foster care must be developed and must specifically include the health records of the child, including names and addresses of providers, a record of immunizations, any known medical problems, medications, and any other relevant health information. The above-cited OIG report found discrepancies in the documentation of mental health services for nine of 50 sampled children. A related federal provision requires that a child’s health records be reviewed, updated, and supplied to the foster care provider with whom the child is placed at the time of each placement. Georgia law and policy likewise require caseworkers to provide a copy of the health information on the child to the foster care provider, and to document that the provider received the information. Despite these clear dictates, the OIG found that less than half of the foster care providers interviewed confirmed receipt of medical information, despite the assigned caseworkers reporting they had received or compiled some medical information for the involved children.

**POLYPHARMACY WITHIN THE FOSTER CARE POPULATION**

In addition to concerns about general safety, concerns increasing rates of polypharmacy -- the concomitant use of multiple medications, from the same or different drug classes, at the same time -- has grabbed the attention of the public and system professionals. Combination drug therapies used in pediatric patients are difficult to justify in the absence of evidence of safety and effectiveness. High-risk practices involving excessive numbers of psychotropic medications have been the focus of recent Congressional inquiry and litigation. Consequently, these practices have become the most obvious target for reforms. According to experts, most psychotropic medication combinations lack adequate evidence of effectiveness and safety in

60 OIG REPORT, supra note 55.
63 Id.
64 Foster Kids Prescribed Psychotropic Drugs, supra note 1.
65 See Hearing, supra note 1.
66 See e.g., Henry A. v. Willden, 2010 U.S. Dist. LEXIS 115006 (D. Nev. 2010) (alleging state failures to provide necessary medical and mental health care to children in foster care as illustrated by the case of an 11 year-old boy who was hospitalized and suffered near organ failure as a result of an adverse reaction to psychotropic medications).
Further, data reveal that children have adverse reactions that differ from adult reactions, depending on the maturity of their organ and metabolic systems.\textsuperscript{68}

Nevertheless, rates of polypharmacy parallel increasing psychotropic medication utilization rates. As such, polypharmacy has become an accepted practice in pediatric psychopharmacology, despite the limited empirical base to support any treatment advantages.\textsuperscript{69} As evidence of the rate of polypharmacy in Georgia’s foster care system, the DCH report previously referenced states that 17.3% of children in foster care are prescribed two or more different psychotropic medications, and nearly 5% received 5 or more during the course of a year.\textsuperscript{70} Psychotropic medications were specifically identified in the records of 80 of 93 cases reviewed through the Georgia Project. Only six of those 80 children were on a single psychotropic medication at one time; the rest varied from between two to ten medications prescribed concurrently. Comparatively, of Connecticut Medicaid-covered youth for whom psychotropic medications were prescribed, 13.6% received more than one such medication from different drug classes.\textsuperscript{71} Similarly, of Texas foster children who had been prescribed psychotropic medication, 41.3% received three or more different classes of these medications, 15.9% received four or more different classes, and 22.2% were given two or more medications from the same class concomitantly.\textsuperscript{72} Because they lack empirical support, these combinations themselves signal reason for concern.

\section*{POTENTIAL MISUSE OF ANTIPSYCHOTIC MEDICATIONS AS CHEMICAL RESTRAINT}

As with psychotropic medications more generally, youth in foster care evidence high concomitant utilization of antipsychotic medications, at rates comparable to disabled youth who typically have conditions for which antipsychotic medications are indicated.\textsuperscript{73} Illness severity may account for some portion of the high utilization as described previously, but given the special characteristics of this class, the potential for misuse of these medications as

\textsuperscript{67} Prescription Psychotropic Drug Use Among Children in Foster Care, Hearing before the Subcommittee on Income Security and Family Support of the Committee on Ways and Means, 110\textsuperscript{th} Congress (May 8, 2008), written testimony of Julie M. Zito, Ph.D.

\textsuperscript{68} Id.; See also Mark A. Riddle, Elizabeth A. Kastelic, & Emily Frosch, Pediatric Psychopharmacology, J. OF CHILD PSYCHOLOGY AND PSYCHIATRY, Vol. 42, No. 1 (2001).

\textsuperscript{69} Multiple Psychotropic Pharmacotherapy, supra note 46; see also Daniel J. Safer, et al., Concomitant Psychotropic Medication for Youths, American J. of Psychiatry, Vol. 160, No. 3 (2003) (reviewing clinical research and practice literature relating to the prevalence and patterns of concomitant psychotropic medication given to youths with emotional and behavioral disorders).

\textsuperscript{70} DCH REPORT, supra note 18.

\textsuperscript{71} Multiple Psychotropic Pharmacotherapy, supra note 46.

\textsuperscript{72} Psychotropic Medication Patterns Among Youth in Foster Care, supra note 25.

\textsuperscript{73} Susan dosReis, et al., Antipsychotic Treatment Among Youth in Foster Care, PEDIATRICS, available at http://www.pediatrics.aappublications.org (Nov. 21, 2011).
chemical restraints is also worth discussion. Many studies reveal antipsychotic medication dispensing for behavioral dysregulation rather than for use in bipolar disorder or psychotic disorders, as indicated by the FDA.

Traumatic experiences produce aggressive behaviors. Accordingly, children in foster care who have experienced trauma have significant behavior problems and difficulties adapting, which often take the form of aggression toward self and others. Studies of youth in foster care have documented antipsychotic prescribing trends that are unsupported by clinical research, suggesting that atypical antipsychotic medications are often used to control aggression rather than for indications of psychosis. For example, in a convenience sample of psychiatric outpatients in the general, non-foster care population, 77% of youth who received an antipsychotic medication did not have a psychotic disorder. Another broad-based, multi-year study of children in the general population found approximately one-third of child and adolescent outpatient visits with prescriptions of antipsychotic medications were for children diagnosed with mood disorders, not psychotic disorders. Additionally, one-third of visits with prescription of antipsychotic medications included a co-prescription for either an antidepressant medication or a mood stabilizer. These findings are consistent with previously cited research reporting the most common concomitant psychotropic class combinations dispensed to youth in foster care as: antipsychotics with ADHD medications, antipsychotics with antidepressants, and antidepressants with ADHD medications. Research on the clinical characteristics of youth who receive antipsychotic treatment confirms associations between the prescription and the youth’s non-psychotic behavior. Though this phenomenon could not

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74 See e.g., Patricia Chamberlain, Leslie D. Leve & David S. DeGarmo, Multidimensional Treatment Foster Care for Girls in the Juvenile Justice System: 2-Year Follow-Up of a Randomized Clinical Trial, J. of Consulting and Clinical Psychology, Vol. 75, No. 1 (2007), (citing studies that demonstrate girls’ involvement in juvenile justice often follows from exposure to trauma and abuse and often co-occurs with anxiety and mood problems, negative interpersonal relationships and social aggression).

75 See Antipsychotic Treatment Among Youth in Foster Care, supra note 73 (finding that youth in foster care receive antipsychotics concomitantly primarily for conduct disorders, despite the lack of empirical support justifying such use).


78 Id.

79 Psychotropic Medication Patterns Among Youth in Foster Care, supra note 25.

80 See Purva H. Rawal, John S. Lyons, James C. MacIntyre, & John C. Hunter, Regional Variation and Clinical Indicators of Antipsychotic Use in Residential Treatment: A Four-State Comparison, J. Behavioral Health Services and Research, Vol. 31 (2004) (finding that antipsychotic treatment was significantly related to delinquent behavior, substance abuse, sexually abusive behavior, and other behavioral problems in a sample of youth in residential treatment).
be evaluated through the Georgia Project, the state’s recent experience with the misuse of medications to control behavior of foster youth is well documented. Foster care providers have been cited by state regulatory bodies and reported by public media for using psychotropic medications to subdue children for the convenience of the staff and often without prescriptions authorizing the use of those medications.  

RECOMMENDED OVERSIGHT FRAMEWORK
The recent GAO report relies on a set of Best Principle Guidelines published by AACAP as the benchmark against which select state’s oversight processes were evaluated. Those guidelines include four categories: consent, oversight, consultation, and information. Expecting that impending federal guidance will also use AACAP’s framework, those principles are employed to organize the findings and recommendations from the Georgia Project as well, in order to inventory work already in progress and to identify clear future directions. Though Georgia does not yet have a formal oversight process, the responsible agencies within the state have taken steps that can be credited against this matrix to determine what actions remain to fully implement a model oversight process.

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<thead>
<tr>
<th>AACAP Guideline</th>
<th>Identify the parties empowered to consent for psychotropic drug treatment for youth in state custody in a timely fashion</th>
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This AACAP standard promotes adoption of a consent process that is both documented and monitored to ensure that caregivers are aware of relevant information such as diagnosis, expected benefits and risks of treatment, common side effects, and potentially severe adverse events.

**Mental Health Agency Policy**
Georgia’s Department of Behavioral Health and Developmental Disabilities (DHBDD), the state’s mental health authority, issued a policy concerning informed consent for psychotropic medication treatment for child and adolescent patients, which became effective October 1, 2010. This policy contains all of the AACAP-recommended components and governs DHBDD-contracted providers, including local community service boards, private providers, and the state mental health hospitals. The primary principle articulated in the policy is to assure that each individual receiving psychotropic medication is aware of the benefits, side effects, and available

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treatment alternatives, including no treatment; thus, informed consent is required for each psychotropic medication prescribed and must be renewed annually. To that end, open communication about the recommended medication is encouraged, which includes education and is documented in the record. The policy further includes an express prohibition on the use of medications for purposes of punishment or for caregiver, staff, or parental convenience. Finally, the policy directs the physician to obtain assent from the youth in addition to obtaining informed consent from the youth’s parent or legal guardian. Despite its strengths, DBHDD policy cannot answer for the state who should be the legal consenter on behalf of a child in foster care because it is not a custodial agency. Rather, DHS-DFCS is the proper authority to determine, consistent with the law, who is the legal consenter to medical treatment for a child in foster care.

Child’s Right to Participate in Treatment Decision-Making
The U.S. Supreme Court has expressed a clear position on the rights of the child in cases addressing medical decision-making. In the well-known Georgia case of Parham v. J.R., the U.S. Supreme Court asserted that “[i]t is not disputed that a child, in common with adults, has a substantial liberty interest in not being confined unnecessarily for medical treatment and that the state’s involvement in the commitment decision constitutes state action under the Fourteenth Amendment.” Though Parham involved the involuntary commitment of a child to state custody, its analysis is relevant to the present issue as the mind- and body-altering effects of medications can be as limiting of a person’s liberty as bodily restraints.

The Supreme Court of Georgia likewise has affirmed the existence of a child’s constitutional right to refuse medical treatment. In the case of In re L.H.R., the Supreme Court of Georgia considered the circumstances under which life-support may be removed from a terminally-ill child existing in a chronic vegetative state with no hope of development or cognitive functioning. The court first looked to the decision in In re Quinlan, which upheld a constitutional right to refuse medical treatment found within an individual’s right to privacy and agreed that the right is not lost because of the incompetence or the youth of the patient. Thus, the child possesses a right to refuse treatment; however, the child may not be legally

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83 Id. Provisions are made for procedures to obtain informed consent in the event of a psychiatric emergency, defined as imminent risk of harm to self or others.
84 Id.
85 Id.
86 Id.
90 In re L.H.R., supra note 88 at 440.
competent to exercise the right on his own behalf. Indeed, as a matter of statute and case law, Georgia only recognizes an adult’s right to refuse treatment. Therefore, as a practical and legal matter, a child’s parent or legal guardian typically expresses the child’s right on behalf of the child.

Georgia statute expressly authorizes a parent to grant consent to medical treatment on behalf of his minor child and also extends that right to “[A]ny person temporarily standing in loco parentis, whether formally serving or not, for the minor under his or her care; and any guardian, for his or her ward.” This latter provision provides a clear legal basis for DHS-DFCS to function as the child’s legal consenter, though it is not clear whether the position of the legal guardian supersedes that of a parent with respect to medical treatment decisions for a child in foster care, provided termination of parental rights has not occurred.

States vary in their procedures for providing consent for prescribing psychotropic medications for children in foster care. The most common method is for the legal guardians or parents to give consent, followed by caseworkers and court order. A few states have designated officials or offices to provide consent for psychotropic medications.

Child Welfare Agency Policy

Georgia DHS-DFCS does not have a policy specifically addressing consent to psychotropic medications. However, practice guidelines were created during the course of the Project. Those guidelines, which are still pending approval, require that the DHS-DFCS County Director or designee obtain, and renew every six months, informed consent for each psychotropic medication prescribed. This practice would limit the use of blanket, or pro re nata, authorizations, which is a positive step forward. Another positive is the inclusion of the specific components of informed consent to include at a minimum, the child’s diagnosis and prognosis, target symptoms, risks and benefits of pharmacological treatment, common side effects and

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91 O.C.G.A. § 31-9-7 (2011); see also Novak v. Cobb County-Kennestone Hospital Authority, et al., 849 F.Supp. 1559 (1994) (holding that Georgia does not recognize the right of a “mature minor” to refuse unwanted medical care).
93 Justice Brennan, Parham “the social worker-child relationship is not deserving of the special protection and deference accorded to the parent-child relationship and state officials acting in loco parentis cannot be equated with parents.” Parham, 442 U.S. at 638 (Brennan, J., concurring in part and dissenting in part).
95 Id. (reporting on Illinois where the Department of Guardian and Advocacy provides consent to medical care, Connecticut where designated program supervisors provide consent, and Tennessee where regional health nurses fulfill the consent responsibilities).
96 GEORGIA DEP’T OF HUMAN SERVICES DIVISION OF FAMILY AND CHILDREN SERVICES, GUIDELINES FOR PSYCHOTROPIC MEDICATION USE IN CHILDREN AND ADOLESCENTS (December 2011).
rare or severe potential adverse events, alternatives to the proposed medication, the risks and benefits of foregoing treatment, necessary laboratory studies and potential medication interactions.97 A copy of a conforming consent form is to be provided to each placement provider, who will be required to notify DHS-DFCS when the medication is received, changed, or discontinued.98 A set of principles governing medication safety is also provided to help the caseworker be a knowledgeable consumer on the child’s behalf.

In addition to these pending guidelines, DHS-DFCS authority over children in foster care includes the exercise of “such rights as determining the nature of care and treatment of the child, including routine medical and dental care.”99 The majority of state child welfare agencies have adopted similar policies, defining the scope of their legal duty as a right to determine “ordinary” or “routine” medical care without further specification as to what decisions are considered to be routine. A few specifically include or exclude psychotropic medications in their agency policy definitions or as a matter of law.100

The scope of the agency’s legal duty to provide “routine medical care” implicates the rights of the parent who would otherwise possess the authority to consent to the child’s treatment. Consider the case of In re G.K., decided in 2010.101 G.K. and his siblings were removed from parental custody when G.K. was not yet two years old as a result of his mother’s substance abuse and mental illness and his father’s abandonment.102 G.K. displayed serious emotional and behavioral health needs, resulting in diagnoses of ADHD and Oppositional Defiant Disorder at age five and an additional diagnosis of Bipolar Disorder at age six.103 When G.K. was 11 years old, the District filed a motion for an emergency hearing concerning his need for psychotropic medications.104 At the time, G.K. was being admitted for a third hospitalization, and his mother had refused to consent for the hospital to administer his medications.105

97 Id.
98 Id.
99 Manual, Section 1011.2.
100 See e.g., 10A Okl. St. § 1-3-102(A)(1) (2011) (defining “routine and ordinary medical care and treatment” specifically to include the provision of psychotropic medication); see also Fla. Stat. § 985.03(39) (2011) (defining “ordinary medical care” to include the provision of psychotropic medications); but see Cal. Welf. & Inst. Code § 369.5(a) (2012) (vesting the authority to make orders regarding the administration of psychotropic medications to foster children with the court).
101 See In re G.K., 993 A.2d 558 (D.C. Cir. 2010).
102 Id. at 560.
103 Id.
104 Id. at 562.
105 Id.
By statute in the District of Columbia, “legal custody” is defined to include the responsibility to provide the child with “ordinary medical care.” Furthermore, the rights of a legal custodian are explicitly subordinated to the rights of the guardian and any residual parental rights. Accordingly, the court found that the child welfare agency did not have the ultimate responsibility to make decisions about whether continuing medication was in the child’s best interest because psychotropic medication did not constitute “ordinary medical care,” within the meaning of the statute. The authority to consent to administration of psychotropic medication is a right retained by a parent, even if that parent has temporarily lost custody, subject to the court’s ability to intervene if necessary to protect the child’s best interest.

Because the statutorily enumerated powers of the DHS-DFCS do not specifically address the agency’s authority to consent to psychotropic medications for youth in foster care, agency policy should more clearly delineate what treatments are encompassed within the agency’s duty to provide “routine medical care.” That is, policy should clearly specify whether the administration of psychotropic medications is, in fact, considered to be “routine” medical care. That determination immediately presents the need for further clarification as to how the parent(s) and child will be consulted and engaged, being mindful of the legal implications of those practices and procedures. Finally, policy should be explicit as to the agency’s authority to proceed with court action if the parent withholds consent or otherwise makes a treatment decision that is believed to jeopardize the health or safety of the child. The law permits the agency to petition the court to issue an overriding the parent’s decision based on clear and convincing evidence that the recommended treatment is in the best interest of the child. On the other hand, if the administration of psychotropic medications to a child in foster care is considered to constitute routine medical care, the agency may make treatment decisions for the child on the advice of qualified medical professionals without first consulting with the child’s parent. Arguably, best practice would still maintain that involving the biological parent

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106 Id. at 564.
107 Id.
108 Id.
109 Id. at 570.; But see In the Interest of Bryan Karwarth, 199 N.W.2d 147 (Iowa Sup. Ct. 1972) (holding that the legal custodian’s statutory duty to provide ordinary medical care presupposes a right to do so in appropriate circumstances over parental objection even in the absence of immediate risk to life or limb).
110 See O.C.G.A. §49-5-8 (2011) (describing in general terms the powers and duties of the department to include child welfare services, boarding care, casework services to courts, etc.).
111 See e.g., In the Matter of Lyle A., 830 N.Y.S.2d 486, 490 (Fam. Ct. NY 2006) (finding the agency’s practice of having the caseworker, rather than the prescribing physician, speak with the parent about the recommended treatment and the lack of a procedure to handle parental requests for changes in treatment to be legally insufficient).
112 Generally, parental rights are considered coextensive with the best interest and rights of a child. As stated by the court in L.H.R., the beginning presumption is that the parent has the child’s best interest at heart,” noting that a departure from this presumption may be made in a case of suspected abuse or neglect.
in the treatment decision increases parental capacity and is consistent with core principles of family-centered practice. Including parents in the treatment decisions makes them informed consumers and empowers them to assess and monitor the child’s response to treatment, which is essential to the child’s long-term well-being.

**Documentation of Informed Consent**

Cases reviewed through the Georgia Project were consistently lacking in documentation of informed consent. Moreover, case records revealed that when a child is placed in a residential treatment facility, the case worker often endorses the provider’s blanket authorization to provide medication to the child, allowing the facility to determine changes in medication without seeking specific informed consent for each change. In this additional way, the practice of obtaining informed consent on behalf of a child in Georgia’s foster care should be improved.

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<th>AACAP Guideline</th>
<th>Establish a mechanism to obtain assent for psychotropic medication management from minors when possible</th>
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As previously discussed, children are generally considered to be legally incompetent to provide consent; however, they must have a role in the decision-making in order to ensure full understanding of and adherence to the treatment. Thus, the participation of children should be considered in the role of assenter, rather than consenter. Assent and consent have similar but distinct meanings. Both indicate an informed acceptance of a treatment recommendation, but assent traditionally denotes agreement with the opinion whereas consent usually denotes permission. The difference turns on who has the legal authority to grant authorization for the recommended treatment.

Patient adherence to prescribed drug regimens is critical to ensure treatment safety and efficacy. Nonadherence can pose significant risks, including reduced efficacy, symptom

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113 Pro re nata (PRN) medications are standing orders that allow caregivers in a group home, residential, or hospital setting to administer psychotropic medication without specific approval and as such, may encourage reliance on the use of medications to manage disruptive behaviors.

114 See Louis a. Weithorn & Susan B. Campbell, *The Competency of Children and Adolescents to Make Informed Treatment Decisions*, 53 CHILD DEV. 1589, 1595 (1982) (finding that choices made by 14 year-olds did not differ significantly from those of adults in terms of comprehension, understanding of alternatives, rational reasoning, and decision making processes when responding to medical and psychological treatment hypotheticals); see also Thomas Grisso & Linda Vierling, *Minors’ Consent to Treatment: A Developmental Perspective*, 9 PROF. PSYCHOL. 412, 417-418 (1978) (asserting that by age 15 children possess psychological abilities that are important to the decision-making process and are no less competent than adults to give consent).

rebound, and withdrawal. Thus, the patient’s complete understanding of his diagnosis and acceptance of his treatment becomes vital. Typically, the process of informed consent promotes the necessary discussion of questions and concerns in an ongoing and dynamic fashion between the patient and the physician. That same process should be undertaken to obtain the youth’s assent.

Many youth in foster care are old enough to understand dosing information and indicated uses for the psychotropic medications prescribed to them. Customary medical practice supports youth engagement by recognizing a role for the youth as assenter. Indeed, the DBHDD informed consent policy requires a medical practitioner, defined to include a licensed physician, certified physician assistants, or advanced practice nurses, to obtain informed consent from the youth’s parent or legal guardian and also to obtain assent from the youth. Unfortunately, the DHS-DFCS practice guidelines in their current form do not reference a role for or provide in any way for direct engagement of the youth. The lack of involvement of the youth-patient was evident in the cases reviewed through the Georgia Project, which found that assent to medication use for documented symptoms of mental illness was not always reported in clinical documentation. Furthermore, informed consent documentation was sparse and routinely obtained by registered nurses rather than one of the professionals referenced in DBHDD informed consent policy cited above. DHS-DFCS policy should be strengthened to promote youth engagement for the long-term goals of encouraging treatment adherence and empowering the youth to be an informed consumer.

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<tr>
<th>AACAP Guideline</th>
<th>Obtain simply written psycho-educational materials and medication information sheets to facilitate the consent process</th>
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To facilitate the consent and assent process, AACAP further recommends obtaining simply written psycho-educational materials and medication information sheets to facilitate the consent process. This standard encompasses both the consent form and educational materials to increase the knowledge capacity of the child, his parents, and agency professionals.

Presently, DHS-DFCS issues consent through a caseworker signing-off on the consent form provided by the individual clinician. These forms differ in their structure and content, and all may not contain essential elements. For this reason, DHS-DFCS is encouraged to develop a standard informed consent form to use on behalf of all children requiring medication, to be

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116 See generally Minors Consent to Treatment, supra note 114 (addressing age competencies for consent to medical treatment).
117 GEORGIA DEP’T OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES, PSYCHOTROPIC MEDICATION PARAMETERS FOR SEVERELY EMOTIONALLY DISTURBED (SED) CHILDREN AND ADOLESCENTS (2010).
used with all providers, and to be maintained in a child’s case record with periodic updates as required by policy. Alternatively, DHS-DFCS could adopt the consent form developed by DBHDD and promoted for use by its contracted mental health service providers.

To satisfy this recommendation as to educational materials, DHS-DFCS with its partner agencies would need to create and/or compile such information and make it available to facilitate the informed consent process. Helpful materials already exist, published by AACAP, including their “Facts for Families.” Additionally, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) plans to help this special population by developing educational materials that could be used once available.

| AACAP Guideline                                                                 | Establish training requirements for child welfare, court personnel, and/or foster parents to help them become more effective advocates for children in their custody |

AACAP promotes a training standard as an ideal oversight measure. At the time the Georgia Project was initiated, no training existed to enable foster parents, relative caregivers, or youth to become more sophisticated mental health consumers or advocates. Moreover, no routine training was available for caseworkers, attorneys, judges or other child welfare system professionals. The Georgia Project attempted to fill this void, reaching a broad cross-section of system stakeholders with training designed to increase knowledge capacity and promote advocacy. Comprehensive trainings were conducted with DHS-DFCS caseworkers, investigators and administrators as well as separately with foster parents, Court Appointed Special Advocates, attorneys, judges, and mental health service providers. Materials developed for these trainings can be made available for continued use by DHS-DFCS or others interested in developing the recommended training standard.

Child welfare workers who attended the two-part training were administered a survey before and after the training. The results of these surveys demonstrated an improvement in their knowledge of psychiatric diagnoses and related psychotropic medications. More importantly, attendees reported this increased knowledge enhanced their ability to serve as effective advocates in their decision-making role related to informed consent. DHS-DFCS is encouraged to develop a training curriculum and educational opportunities for agency personnel and external stakeholders, all of whom contribute to realizing well-being outcomes for youth in foster care.

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119 See Joint Letter, supra note 5.
Guidelines governing the prescription of psychotropic medication can be found in the form of drug formularies, prior authorization programs, and utilization management approaches. Although policy-makers are generally reluctant to interfere with access to treatment, concerns about safety and escalating costs have led some states to adopt such utilization management strategies for psychotropic medications. These medications can be an important part of a comprehensive, integrated, and strategic mental health treatment intervention, and policy makers generally feel that doctors are in the best position to make decisions about their use. However, as with many types of medications, states have developed medication prescribing guidelines and peer-review or prior authorization mechanisms on the theory that increasing the standardization of clinical care may reduce variations in care based on individual child characteristics.\(^{120}\) Georgia has made significant progress in this area, having already adopted medication utilization parameters and instituted a prior authorization program for second-generation atypical antipsychotic medications administered to children.

**Medication Utilization Parameters**

DBHDD published its “Psychotropic Medication Utilization Parameters for Severely Emotionally Disturbed (SED) Children and Adolescents” to accompany its informed consent policy. A copy of the informed consent policy and the parameters is included in Appendix A. The introduction to those parameters acknowledges the multiple and complex needs of children in state care, which present challenges for accurate diagnosis and treatment.\(^{121}\) Following a list of general principles, DBHDD presents a series of criteria that may indicate the need for further review of a child’s clinical status.\(^{122}\) As part of the Georgia Project, similar prescribing guidelines from other states were compiled and compared with the DBHDD parameters.\(^ {123}\) Georgia’s guidelines compare favorably, reflecting elements common to other state examples. Additionally, several child psychiatrists and service administrators were convened through the Georgia Project to review and discuss the DBHDD guidelines. Those meetings yielded suggestions for technical revisions to the parameters, which are included in Appendix B.


\(^{121}\) GEORGIA DEP’T OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES, *PSYCHOTROPIC MEDICATION PARAMETERS FOR SEVERELY EMOTIONALLY DISTURBED (SED) CHILDREN AND ADOLESCENTS* (2010).

\(^{122}\) Id.

\(^{123}\) State parameters that were reviewed as part of the Georgia Project included those from Arizona, Connecticut, Illinois, Kansas, New York, Oregon, Tennessee, and Texas.
The DBHDD medication parameters are included in the agency’s provider manual, though issues of awareness and enforcement persist. In order to realize the goal of greater practice consistency, DBHDD should continue to promote the guidelines and implement a mechanism for monitoring compliance. Providers who are routinely identified as responsible for prescribing patterns that consistently fall outside the medication utilization parameters should be jointly scrutinized by DBHDD, DHS-DFCS, and DCH to facilitate a multi-system response. Multi-agency collaboration in other states has resulted in established mechanisms to provide telephone and/or electronic access to psychiatric consultation that yields an informed consent recommendation to the child welfare agency prior to authorization of payment by Medicaid. Other oversight models attempt to normalize prescribing practices through explicit comparisons of prescribers to each other with respect to, for example, use of generic alternatives and adherence to the state’s preferred drug list.

**Prior Authorization Program**

As use of prescription medications increases, overall expenditures likewise increase. Increases are particularly marked with respect to psychotropic medications and antipsychotic medications as a subclass. In 2003, total sales of antipsychotic agents amounted to $8.1 billion, representing an increase in spending of 22.1% over the previous year. Among the antipsychotic class, growth has mainly been with second-generation products, of which Medicaid is the nation’s dominant purchaser, accounting for approximately 80 percent of all antipsychotic prescriptions in 2001. Nationally, Medicaid spent five times more for antipsychotics in 2001 than it did in 1993, a trend driven mostly by a shift in use to more expensive, newer antipsychotic medications. Youth in foster care specifically have been found to be as likely to receive antipsychotic medications concomitantly as were disabled youth eligible for Medicaid through SSI disability status. In addition to its cost considerations, antipsychotic polypharmacy has been associated with adverse effects that only heighten public

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125 Id.
126 See Julie M. Zito, et al., *Psychotropic Medication Patterns Among Youth in Foster Care*, Pediatrics, Vol. 121 (2008) (finding less than 1% of the antipsychotic agents prescribed in a sample of Texas foster youth were of the conventional type).
128 Id.
concern. Specifically, second-generation antipsychotics have been found to carry a greater risk of metabolic and endocrine adverse effects among children.\textsuperscript{130}

Prior authorization is a cost-containment and clinical review procedure that requires a prescriber to obtain approval from Medicaid to prescribe a medication prior to prescribing it, with the opportunity for denials to be appealed. The medications requiring prior approval may be considered “nonpreferred agents” or may be drugs with efficacy in a specific population or disease state or that have significant side effect profiles when compared to currently available treatments. A particular medication can become “nonpreferred” on the basis of its acquisition costs or on the basis of its therapeutic value (including off-label use) as compared with other available treatments. In this way, prior approval processes can be leveraged as instruments of policy, as opportunities to ensure clinically-appropriate use of a medication prior to use or to document positive results prior to continued use. Of note, the Kaiser Commission on Medicaid and the Uninsured reports that by fiscal year 2011, 46 states had adopted a prior authorization program.\textsuperscript{131} Further, 16 states between fiscal year 2010 and fiscal year 2011 reported implementing or planning to implement a cost containment action focused on specialty medications.\textsuperscript{132}

Prior authorization programs processes are frequently criticized for their unintended consequences, including a substantial burden on provider and patient time, increased treatment discontinuities, and reduced quality of care.\textsuperscript{133} Studies of the impact of prior authorization programs have generally shown substantial cost savings for the targeted medications\textsuperscript{134} but mixed results on the quality of care. Some studies indicate that these policies may result in interruptions in medication treatment which, in turn, can be associated with negative patient outcomes and increased non-drug health care utilization that may offset any reductions in direct pharmacy costs.\textsuperscript{135} For example, a recent study of Medicaid patients in

\textsuperscript{130} See e.g., C.U. Corell, \textit{Multiple Antipsychotic Use Associated with Metabolic and Cardiovascular Adverse Events in Children and Adolescents}, \textit{EVIDENCE BASED MENTAL HEALTH}, Vol. 12, No. 3 (2009) (reporting the incidence of weight gain, type 2 diabetes, and dyslipidemia among children and adolescents to be 2.3 to 5.3 times greater among those who receive multiple antipsychotics); see also C.U. Corell, \textit{Endocrine and Metabolic Adverse Events of Psychotropic Medications in Children and Adolescents}, \textit{J. AM. ACAD. CHILD AND ADOLESCENT PSYCHIATRY}, Vol. 46, No. 7 (2006).

\textsuperscript{131} Kaiser Commission on Medicaid and the Uninsured, \textit{Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends, Results From a 50-State Medicaid Budget Survey for State Fiscal Years 2011 and 2012} (2011), pp. 54-57.

\textsuperscript{132} \textit{Id.} at 55.


\textsuperscript{134} \textit{But see id.} (finding that the impact of prior authorization policies on pharmacy reimbursement was minimal, despite a significant shift in market share).

\textsuperscript{135} \textit{Id.}
ten states concluded that patients experiencing “medication discontinuations, gaps, switches or other access problems attributed to prescription drug coverage and management” had 73.8% more emergency department visits and 71.7% more acute stay hospital days compared to matched patients without access problems reported.” Overall, patients had worse outcomes and any cost benefit was offset by more costly hospital or emergency care.

Georgia’s Department of Community Health (DCH) administers the state’s Medicaid program, for which children in foster care are categorically eligible. In this role, DCH can play an important role in shaping clinical practice and utilization of psychotropic medications for this special population through carefully-crafted policies. In October 2011, DCH instituted a policy requiring prior authorization for children in Fee-for-Service Medicaid who have an atypical (second-generation) antipsychotic medication prescribed when the child is outside the FDA-approved age indication for that drug for the child’s particular diagnosis. The prior authorization request is considered in light of the AACAP guidelines. A paid supply of medication is made available during the appeals process or during the process of referral to a specialist for patients already established on the medications. Nevertheless, some mental health service providers in Georgia have expressed concern about the potential for delay or denial in treatment and some problematic cases have been reported. DCH is closely monitoring all denials and appeals generated by the new program. Additionally, DCH is partnering with the University of Georgia to undertake a study of the impact of this program. As activities to monitor the impact of the prior authorization program proceed, results should be shared with DCH’s sister agencies and made public. Any future changes to the prior authorization program design should be informed by input from clinicians, just as the original program did.

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136 Defined by the study to include (1) medication was discontinued or temporarily stopped as a result of drug coverage, administrative or management issues, or patient copayments; (2) patient could not access clinically indicated medication refills or new prescriptions because they were not covered or approved; (3) patient had problems accessing medications because of patient copayments; or (4) the patient’s physician changed or discontinued medications rather than pursued exceptions or appeals processes.


139 See http://www.aacap.org/cs/root/policy_statements/pharmaceutical_benefit_management_and_the_use_of_psychotropic_medication_for_children_and_adolescents for AACAP’s Policy Statement covering prior authorization requirements.
AACAP Guideline

Oversight program includes an advisory committee to oversee a medication formulary and provides medication monitoring guidelines to practitioners who treat children in the child welfare system.

As an additional feature of an oversight program, AACAP recommends an independent body to oversee prescription drug monitoring activities. Georgia’s Drug Utilization Review (DUR) Board already functions in a review and advising capacity to DCH with respect to the clinical and cost-effectiveness of pharmaceuticals used by children participating in the Medicaid program. The Board, appointed by the DCH Commissioner, is tasked with promoting patient safety through reviews of drug therapies, drug studies and utilization information. The Centers for Medicare and Medicaid Services (CMS) has suggested that this DUR program can be used to monitor dispensing and influence provider behavior. With a balanced mix of physicians, pharmacists, and advocates (including a child welfare expert), Georgia's DUR Board could be leveraged more strategically to realize improvements in areas that specifically impact children in foster care.

AACAP Guideline

Oversight program monitors the rate and types of psychotropic medication usage and the rate of adverse reactions among youth in state custody.

As the state designs its oversight program, periodic reporting on utilization trends will help satisfy the concerns of the public and of child welfare and mental health system professionals. Linkages between DCH pharmacy claims data and child welfare case records maintained in the SHINES database would permit verification and tracking of trends in aggregate and individual utilization. Such an exchange could facilitate better coordination of care and detection of concerning prescription patterns as practice becomes better informed. Reports should be shared regularly with the public and with the local DFCS county offices to facilitate case-level monitoring and action in relation to the DBHDD medication guidelines. The data would also guide the activities of the consultation program discussed herein.

Linkages between Medicaid administrative claims data and the child welfare case management database (SHINES) would permit better tracking and coordination of care, assessed according to type of placement setting. DCH data would shed light on utilization, and properly documented DFCS case records could facilitate deeper understanding and tracking of adverse reactions experienced by children in care. Such an exchange would also facilitate detection of prescription patterns and identification of prescribers who are administering medications in ways believed to be problematic.

140 JOINT LETTER, supra note 5.
The DBHDD medication guidelines include criteria for seeking further review of a child’s treatment. Those guidelines, informed by clinical standards of care, establish routine and permissible uses of medications while recognizing that individualized treatment planning for a specific child may fall outside the parameters. To the extent a recommended treatment falls outside of those parameters, it should trigger an independent review and consultation with, at a minimum, the provider, the legal guardian, the child, and the parent.

Aggregate-level reporting will increase system accountability and transparency. Increased information-sharing will promote uniformity of practice and satisfy the public and system professionals as to the care received by children in state custody. Case-level detail shared with county DFCS offices will facilitate informed advocacy and decision-making to achieve positive outcomes for children on foster care caseloads. As a preliminary need, however, DHS-DFCS should meet with DCH to standardize data collection regarding psychiatric medications for children and youth.

*Medical Passport*

As previously discussed, systemic challenges to the maintenance of an accurate and complete medical record that follows the child as he changes foster care placements and treatment providers critically undermines the delivery of high-quality healthcare services. Children in foster care have complex health needs that require the involvement of many different providers in multiple care settings. Treatment providers and foster care providers both change over time as children move through the foster care system. Electronic health passports or
“medical passports” are a promising practice intervention that can help overcome the barriers created by system fracture.

Health passports come in different forms but are generally conceptualized as a patient-centered, web-based health record. They contain demographic information and a record of the child’s medical history and current levels of treatment. Specific information may include medications, diagnoses, immunization records, allergies, and provider contact information. Because they are electronic and therefore portable, these passports allow for connectivity for caseworkers, foster care providers, biological parents, clinicians, judges, attorneys, and others. Because it contains sensitive and personal health information, the passport should be treated with provided to the placement resource and reviewed at every medical appointment by the health care provider. Moreover, a medical passport can be provided to a youth who is aging-out of care or to a youth’s parent or caregiver at exit so as to facilitate a successful health care transition. And finally, these electronic records also function to collect data about the foster care population as a whole which could be analyzed to more accurately understand the health care needs and service utilization of this population.

A handful of states have implemented medical passports for children in foster care, and available evidence of the impact of these tools points to improved outcomes including reductions in the number of children in residential programs, declining hospitalization rates, and decreased cost of care.\(^ {141} \) DeKalb County DFCS instituted a paper-based Health and Education Passport in January 2010 to improve efforts to meet the ongoing medical needs of children in that county’s foster care system. Early reports suggested inconsistent use and mixed results, largely due to a lack of buy-in from caseworkers and their supervisors.\(^ {142} \)

Though underutilized, a structure for electronic recordation of health information presently exists within the SHINES case management database used by all Georgia DHS-DFCS offices. The SHINES record includes a Health Log page for documentation of the health and medical needs of children. As part of the Health Log, a Medication Detail page is available to record prescribed medication and changes made to medication regimens. Quality assessment measures should be implemented to ensure caseworkers are consistently documenting comprehensive medical


\(^ {142} \) Email from Betsy Scott, Kenny A. IPO Specialist, DeKalb County Division of Family and Children Services, to Melissa D. Carter, Director, Barton Child Law and Policy Center, Emory University School of Law (June 29, 2011) (on file with author)(noting as problematic that administrative staff could not keep up with providing passports for newly opened case, that workers did not consistently use the passport in practice, and that supervisors did not routinely track or insist upon workers’ use of the passport).
information and maintaining it accurately, as required by agency policy. Furthermore, protocols should be developed to facilitate the appropriate sharing of this information with caregivers, treatment providers, the child’s guardian *ad litem* and attorney, and the court, as needed to facilitate coordination of care.

*Medical Home*

The concept of a “medical home” is related to that of a medical passport inasmuch as it is envisioned to be a central source for all medical information about a child and for providing connections between and among treatment providers. Of note, through temporary enhanced federal reimbursement, the recently enacted Affordable Care Act provides a new opportunity for states to implement a medical home model for children in foster care who suffer from chronic conditions.\(^{143}\) Additionally, Medicaid incentive payments are available to certain providers who use Electronic Health Records (EHR) technology.\(^{144}\)

<table>
<thead>
<tr>
<th>AACAP Guideline</th>
<th>Design a consultation program administered by child and adolescent psychiatrists. This program provides consultation by child and adolescent psychiatrists to the persons or agency that is responsible for consenting to treatment with psychotropic medications.</th>
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As of early January 2012, DHS has added a state Medical Director to its administrative structure. The improvement of monitoring of psychotropic medication among children in foster care will be a priority for this new position. As such, the Medical Director should design and lead a consultation program informed by the AACAP guidelines.

Several state child welfare agencies use mental health and psychiatric consultation as part of the consent and monitoring process and could be looked to as models. In Illinois, the child welfare agency contracts with a university to provide an independent review of all psychotropic medication requests by a board-certified child and adolescent psychiatrist.\(^{145}\) That psychiatrist is also available to consult with caseworkers and clinicians.\(^{146}\) Tennessee has centralized the consultation function by requiring that all psychotropic medication requests be forwarded to a regional nurse if a parent is unavailable.\(^{147}\) Texas provides another example in which the state


\(^{144}\) For more information see [https://www.cms.gov/ehrincentiveprograms](https://www.cms.gov/ehrincentiveprograms).


\(^{146}\) Id.

Medical Director consults with child welfare staff regarding policy, procedures, training materials and complex cases, and provides guidance to staff who are consenting to a child’s treatment with psychotropic medications.

Another example of a consultation program is operating in New Hampshire. The New Hampshire “Child Psychiatrist on Call” program creates a pool of child psychiatrists available for mental health drug review for Medicaid recipients. This model could be adapted for peer-to-peer consultation between child psychiatrists and expert psychiatric consultation with DHS-DFCS caseworkers. A similar model exists in Florida where, since 2004, the MedConsult hotline has been available for families, guardians, and the courts to consult with Board certified child psychiatrists to facilitate informed consent for psychotropic medication to children in foster care. The kinds of information provided include indicated uses, usual and customary practices, dosage ranges, FDA warnings, and routine lab work.

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<tr>
<th>AACAP Guideline</th>
<th>The consultation program provides consultations by child and adolescent psychiatrists to, and at the request of, physicians treating this difficult patient population</th>
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<td>As the state consultation program is designed, consideration should be given to technological advances available through the state’s telemedicine program, which could facilitate consultation between board-certified child psychiatrists and physicians or service providers throughout the state where such resources are scarcer.</td>
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<table>
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<tr>
<th>AACAP Guideline</th>
<th>The consultation program conducts face-to-face evaluations of youth by child and adolescent psychiatrists at the request of the child welfare agency, the juvenile court, or other state or county agencies empowered by law to consent for treatment with psychotropic medications when concerns have been raised about the pharmacological regimen</th>
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<td>Face-to-face evaluations of children referred through the Georgia Project allowed for the safe tapering of psychotropic medications prescribed at dosages up to three times the recommended daily maximum set by the FDA. Furthermore, intraclass prescribing (i.e., prescribing more than 1 medication from the same drug class) referenced in the GAO study was discovered more frequently than expected and involved multiple classes of medications,</td>
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including antipsychotics, mood stabilizers, and alpha-agonist medications (a type of medications used for symptoms of ADHD). Intraclass prescribing may be appropriate for a short duration while one medication is started and another is discontinued. However, prescribing patterns observed during the consultation process revealed intraclass prescribing that persisted for more than a year in many cases. Recommendations were made for the safe reduction of medications to limit the prescribing of two medications indicated for similar symptoms. Frequent use of antipsychotics for behavioral control of children diagnosed with ADHD, oppositional defiant disorder, or conduct disorder was also systematically addressed. These medications can be utilized to limit life-threatening psychotic agitation, but regular use for behavioral control in children is not recommended for extended periods of time. Additionally, an anticonvulsant medication indicated for the treatment of patients with a seizure disorder (oxcarbazepine), but without an FDA indication for mental health symptoms, was also used more frequently and at doses higher than expected by practitioners. These findings reaffirm the value of a face-to-face evaluation component of the consultation program.

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<tr>
<th>AACAP Guideline</th>
<th>Create a website to provide ready access for clinicians, foster parents, and other caregivers to pertinent policies and procedures governing psychotropic medication management. Website includes:</th>
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<td>• Psycho-educational materials</td>
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<td>• Consent forms</td>
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<td>• Adverse effect rating forms</td>
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<td></td>
<td>• Reports on prescription patterns for psychotropic medications</td>
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<td></td>
<td>• Links to helpful accurate, and ethical websites about child and adolescent psychiatric diagnoses and psychotropic medications</td>
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This standard promotes the need for a single, designated repository of relevant information on policies, procedures, and research governing the use of psychotropic medications that is easily accessible by the public and professionals on a continual basis. The DBHDD Provider Manual, which contains its informed consent policy and the medication utilization parameters previously described, is available online, as is DHS-DFCS policy. Ideally, these materials would be consolidated and maintained on a single publicly-accessible website, along with additional helpful content, such as educational materials, forms, period reports, news stories, national resources and other reference tools. The website could be hosted by a university, a local children’s hospital or other community partner.
HOUSE BILL 23

The Georgia Project gained momentum from House Bill 23 (HB 23), the “Foster Children’s Psychotropic Medication Monitoring Act,” introduced by Representative Mary Margaret Oliver in the 2011 session of the Georgia General Assembly.\(^{149}\) The bill proposed the creation of an oversight mechanism to monitor the use of psychotropic medications in Georgia’s foster care system along dimensions consistent with the AACAP guidelines.

The stated goals of HB 23 included bringing the state into compliance with the health care coordination plan requirements of the Fostering Connections Act, providing for the health and well-being of children in foster care, and managing escalating health care costs associated with psychotropic drug prescriptions. To meet those goals, HB 23 requires DHS to institute controls for the use of psychotropic medications, including medication utilization parameters, an independent clinical team to conduct semiannual case reviews, and regulations regarding the provision of “as-needed” prescriptions. Furthermore, the bill calls for the agency regulatory measures to encourage the use of nonpharmacological treatments in lieu of or in addition to medications. House Bill 23 also requires DHS to establish provisions addressing informed consent and notifications to the child, child’s caregiver or foster parent, and legal guardian. Written informed consent must be obtained from the child’s legal guardian and the child if age 14 or older before the medication is started and documented in the case record. Written assent must be obtained from children younger than 14. DHS additionally must create procedures for independent clinical reviews to be triggered when a prescription falls outside of the medication guidelines and a protocol for the provision of psychotropic medication in emergency situations. Reporting, recordation and information-sharing provisions are also included in detail.

The bill’s sponsor decided to delay taking formal legislative action on HB 23 to allow the Georgia Project to proceed. The findings from this report are anticipated to inform any future direction of that legislative measure.

CONCLUSION

The proliferation of psychotropic medications used for the treatment of mental and behavioral health disorders among children in foster care has become an issue of national prominence. Consistently, reports confirm that children in foster care are prescribed these powerful substances at rates far greater than children in the general population. Polypharmacy is also more common among children in foster care, particularly combinations involving antipsychotic medications. These trends are concerning because safety and efficacy of these medications is

not well established, particularly in terms of short- and long-term impact on a child’s developing body and brain.

Research likewise shows that children in foster care are at greater risk for mental and behavioral health disorders, but illness severity and prevalence does not fully explain the higher rates of utilization. The trauma experienced by children in foster care often manifests in symptoms that fit criteria for mental health diagnoses but is better explained – and treated – as a response to the experience of abuse, neglect, and exposure to violence. Achieving the necessary diagnostic clarity is further complicated by varying degrees of system fragmentation. As children in foster care change placements, they often change medical providers, and records are incomplete and inaccurate. Informed consent processes are unclear, and systemic supports for child welfare personnel and providers do not exist. Medications become an expedient solution.

The poor outcomes for vulnerable children achieved at high cost to state Medicaid programs justify the increased oversight called for by recently enacted federal law. Designing a systemic approach to the management of medications in the high-risk foster care population, however, presents significant challenge to policy, practice and agency processes. A systemic solution in Georgia will require intensive coordination between the Department of Human Services, the Department of Behavioral Health and Developmental Disabilities, and the Department of Community Health. Service capacity and programmatic depth must be created to provide the expert consultation, quality assurance, and information flow that are needed to ensure positive outcomes for children in foster care. Additionally, stakeholders at all levels must become informed consumers and knowledgeable advocates on behalf of children in care. Equally as important, children and their families must be engaged in treatment planning in meaningful ways.

Scrutiny of administration of psychotropic medications to youth for whom the state has responsibility will continue so long as these medications remain central to treatment. The quality of care concerns and financial impact concerns fuel a rallying cry for increased oversight, but the response must be tempered by a longer view of system improvement. A balanced approach that preserves the value of medication in the treatment of mental health will best advance the state’s moral and legal duty to children in foster care. Toward that end, the Georgia Project presents recommendations for creating a meaningful and sustainable approach to better mental health care for children.
SUMMARY OF RECOMMENDATIONS

To continue the positive direction toward improvements in the health care outcomes of youth in foster care, particularly with respect to the administration of psychotropic medications, the Georgia Project offers the following recommendations:

1) DHS-DFCS policy should clearly identify who is authorized to provide informed consent to medication treatment for a child in foster care (caseworker, administrator, parent/guardian, foster parent, etc.) and outline the responsibilities of that role;

2) DHS-DFCS should develop clear practice guidance and/or policy to facilitate consistent and meaningful engagement of the biological parent(s) in the course of the child’s treatment, including how the agency should respond to parental requests for changes in treatment;

3) DHS-DFCS should develop clear practice guidance and/or policy to facilitate consistent and meaningful engagement of the child or youth, including procedures for obtaining the youth’s assent to the recommended treatment;

4) DHS-DFCS should adopt a standardized written consent form to facilitate proper, individualized treatment for every child in foster care who needs mental or behavioral health interventions; alternatively, DFCS should coordinate efforts with DBHDD to develop and consistently employ a provider-specific consent form;

5) DHS-DFCS should implement quality assessment measures to ensure proper documentation of the agency or parent’s informed consent and the child’s assent in the case record, including current and complete information entered into the Health Log pages in SHINES;

6) DHS-DFCS should actively explore expanded adoption of an electronic health record / medical passport model, beginning with existing capacity in SHINES;

7) DHS-DFCS should develop explicit protocols for sharing individual case-level information (maintained electronically or in paper form) with treatment providers, foster parents or other caregivers, the child’s attorney or guardian ad litem, and the court, as needed to ensure coordinated care;

8) DHS-DFCS should adopt an express prohibition in policy against the use of psychotropic medications as chemical restraints and for purposes of punishment or convenience of the caregiver, staff, or parent;

9) DHS-DFCS should adopt an express prohibition in policy against the use of as-needed/blanket/pro re nata authorizations;

10) DHS-DFCS, in partnership with DBHDD and DCH, should develop a training curriculum and educational opportunities for agency personnel and system stakeholders (foster parents, judges, attorneys, Court Appointed Special Advocates) to improve understanding of the mental and behavioral health needs of children in foster care, available medication treatments, and nonpharmacological alternatives to medication;
11) DHS-DFCS should coordinate with its sister agencies DBHDD and DCH to promote awareness of and adherence to the DBHDD medication utilization standards among clinicians treating children in foster care through strengthened contract standards or other quality assurance mechanisms;

12) DHS-DFCS, DBHDD and DCH should develop a process for review of cases that fall outside of the medication utilization parameters that includes a “second opinion” capacity involving comprehensive record review by a qualified professional and face-to-face evaluation of children when needed or upon request;

13) DHS-DFCS should partner with its sister agencies DBHDD and DCH to develop a coordinated response to foster care providers/mental health service contractors identified for problematic prescribing patterns;

14) DHS-DFCS should partner with its sister agencies DBHDD and DCH to build service capacity among providers offering evidence-based therapies as alternatives or compliments to medication treatments;

15) DHS-DFCS should develop a consultation program under the direction of the new Medical Director to provide expertise to caseworkers and prescribing physicians;

16) DBHDD should consider the technical revisions to its medication utilization parameters suggested by the clinician workgroup convened as part of the Georgia Project;

17) DCH should continue monitoring the impact of its prior authorization program and make results available through periodic public reporting;

18) DCH should continue to solicit clinician and consumer input concerning any modifications to its prior authorization program;

19) DHS-DFCS, DBHDD, and DCH should establish inter-agency monitoring, information-sharing, and reporting protocols to capture case-level and aggregate utilization trends (rate and type), adverse events, and outlying prescribers, and share relevant detail with providers, caseworkers and administrators, child welfare system stakeholders, and the public;

20) DHS-DFCS, DBHDD, and DCH should centralize relevant policies, procedures, and educational materials on a publicly-accessible website.
INFORMED CONSENT FOR PSYCHOTROPIC MEDICATION TREATMENT FOR
CHILD AND ADOLESCENT POPULATION

POLICY
The Division of Child and Adolescent Mental Health within the Department of Behavioral Health and Developmental Disabilities recognizes an individual's right to exercise informed consent to treatment prior to the administration of psychotropic medication and throughout the course of treatment with such medication. The Division seeks to assure that each individual receiving psychotropic medication as a part of his/her treatment is aware of the benefits, side effects which may occur while taking this medication and the available treatment alternatives, including no medication. The process of Informed Consent helps to encourage and support the discussion of questions and concerns regarding the use of psychotropic medication with a youth and his or her parent/legal guardian and should be actively encouraged. This process is best supported by open, verbal communications, must include medication education and information, administration and dosage information, and must be documented in the medical record. All medications must be used solely for the purposes of providing effective treatment and protecting the safety of the consumer and other persons and not as punishment or for caregiver, staff or parental convenience. Assessment of safety determines whether involuntary administration of medication is necessary. Informed consent for medications should always be documented in a consistent manner and located in the youth's medical record in a designated location for easy accessibility. Crisis Stabilization Programs shall continue to follow policies and procedures in the Informed Consent and Involuntary Administration of Psychotropic Medication in Hospitals, concerning the use of psychotropic medication in involuntary situations.
**Targeted Population(s)**
This policy is applicable to all child and adolescent consumers who are enrolled in mental health and/or co-occurring services contracted by the Department of Behavioral Health and Developmental Disabilities, and who are prescribed psychotropic medications as part of their treatment plan.

**INTRODUCTION**
The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD), has established this policy for obtaining Informed Consent for all DBHDD enrolled child and adolescent consumers who are prescribed psychotropic medications. A medical practitioner (licensed physician, certified physician assistants, or advanced practice nurse pursuant to the written protocol with the physician that meets the statutory criteria) shall obtain informed consent from the youth’s parent or legal guardian, and shall obtain assent from the youth.

A youth’s parent/legal guardian shall give the Informed Consent by signing and dating an acknowledgement that the youth/parent/legal guardian has received the information, and the parent/legal guardian gives consent to the proposed treatment. If the parent/legal guardian is unavailable to sign informed consent documentation, verbal informed consent may be obtained and documented as provided further in this policy.

Please refer to [Attachment A - Psychotropic Medication Utilization Parameters for Severely Emotionally Disturbed (SED) Children and Adolescents](#) for recommended utilization parameters and guidelines for the use of psychotropic medication in the treatment of youth who are served by DBHDD Child and Adolescent Providers. These are the expected parameters for all DBHDD providers serving this target population.

**DEFINITIONS**
Provider – For the purposes of this policy, the term “provider” includes organizations that provide consumer services that are financially supported in whole or in part by funds authorized through DBHDD.

**PROCEDURES**

A. Informed consent shall be obtained from the parent/legal guardian for each psychotropic medication prescribed. The individual medical record must contain documentation of each informed consent.

B. For providers under contract with DBHDD to provide services, DBHDD has developed the [Informed Consent for Psychotropic Medication Treatment for Children and Adolescents](#) form (Attachment B). All DBHDD providers are required to use this form or alternative forms/electronic medical records with the same content or allow prescribers to document informed consent in their Progress Notes. However, all essential elements must be captured in the informed consent documentation, wherever it is located.
DBHDD form "Informed Consent for Psychotropic Medication Treatment for Children and Adolescents" (Attachment B) includes the following essential elements of informed consent:

1.)
- Consumer name and date of birth
- Printed name of each medication
- The diagnosis and target symptoms for the medication being prescribed;
- The FDA status (black box warning, indicated/off-label)
- How the Informed Consent was obtained
- Signature/initialed of parent/legal guardian showing consent or refusal to consent for each psychotropic medication prescribed
- Printed name and signature of medical practitioner

By obtaining signature on the Informed Consent, the practitioner is stating that he/she has discussed the following information with the parent/legal guardian for each medication listed on the Informed Consent:

2.)
- The side effects and potential side effects upon discontinuing as well as the benefits of taking the medication and the intended outcome of treatment;
- Possible medication and treatment alternatives to the proposed medication treatment, including the option of not taking psychotropic medication;
- The potential side effects and results associated with not taking the recommended medication;
- The possibility that psychotropic medication dosages may need to be adjusted over time and in consultation with the medical practitioner;
- Where possible, the practitioner has discussed the above statements with the child at a level and in a manner which the child can understand. The practitioner should attempt to obtain the child’s assent when possible.
- The parent’s/legal guardian’s right and the provider’s responsibility to openly discuss any medication questions and/or concerns and to allow the consumer to actively participate in the treatment planning process regarding the use of psychotropic medication;
- A parent’s/legal guardian’s right to withdraw the Informed Consent for Psychotropic Medications at any time in the treatment process. The provider should, in advance, have reviewed and documented the potential side effects associated with discontinuance of psychotropic medication.

C. Medical practitioners are encouraged to use open-ended questions to assess whether or not the youth/parent/legal guardian understands the issues of informed consent. Information provided in the process of obtaining informed consent must always be communicated in a manner that the youth/parent/legal guardian can understand and comprehend. This should include verbal communication in the youth/parent/legal guardian’s primary language. If necessary, translation services must be obtained.
D. For providers who dispense from their own pharmacy, written information must be provided to the youth/parent/or legal guardian for each new medication prescribed. Such handouts should generally use simple, understandable language. It is recommended that the information in these materials include:

- Name of the medication (generic and brand name);
- What is the common use of the medication;
- What drugs or foods may interact with this medication;
- Important side effects to be aware of;
- What to do if a dose of medication is missed;
- How to take the medication as well as how the medication should be stored;
- Any other specific information pertaining to the medication prescribed.

E. When the medical practitioner is unable to obtain signature on the informed consent by the parent/legal guardian, the provider must discuss verbally the essential elements, as described in section B., 1.) and 2.) above, related to the informed consent process to the parent/legal guardian. Telephonic/verbal Informed Consent must be obtained by the medical practitioner and one additional staff of the provider agency. The medical practitioner should document on the informed consent form or “Unable to sign; Verbal consent given” in the blank for the person's/legal guardian’s signature. The additional staff person must sign in the blank for witness. Written consent must be obtained within 90 days.

F. In the event that medication is administered to a youth when the youth is uncooperative and consent has been obtained from the parent/legal guardian, providers must ensure they are following the standards regarding restrictive interventions, as stated in the Georgia DBHDD Provider Manual, Part II, Community Service Standards, Section I, Standards for All Providers, Section E. Human and Civil Rights are Maintained.

G. Dosage changes for the exact medication do not require a new Informed Consent.

H. Changes in medication within the same class do require a new Informed Consent.

I. When obtaining Informed Consent for two or more medications that are being initiated at the same time, one signature at the bottom of the form, with initials and date for each respective medication, can provide for Informed Consent, provided that each medication is listed separately on the Informed Consent and the parent/legal guardian initials are obtained for each.

J. A renewal of the informed consent process and signatures must be completed every 12 months even in the event there are no changes that occur to the psychotropic medication treatment plan.

K. Unless the youth is maintained under formal legal guardianship upon reaching the age of 18, a new psychotropic medication informed consent must be obtained from the youth as a legally responsible adult.
### Informed Consent for Psychotropic Medication Treatment for Child and Adolescent Population

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#### L. If a child or youth has been removed from the home by CPS (Child Protective Services), and is in the custody of CPS/State of Georgia, the person who is providing informed consent is the Department of Human Services (DHS) through the Division of Family and Children Services (DFCS). If the provider is unable to obtain signature on the informed consent, the provider must thoroughly document efforts taken to obtain the informed consent on more than one occasion, and place those in the medical record of the child/youth. If necessary, this consent may be obtained verbally through the process provided in paragraph E. above.

#### M. In the event of a psychiatric emergency (defined as imminent risk of harm to self or others) that warrants emergency psychotropic medication treatment, an attempt to obtain the Informed Consent, at least verbally, must be made. If an Informed Consent cannot be obtained by the parent/legal guardian, the medical practitioner must complete the documentation on the Informed Consent and should provide a written explanation of the emergency situation in the person's medical record, including the rationale for the emergency use of medication treatment. The medical practitioner will document on the Informed Consent form “Emergency Medication Treatment” in the blank for the parent's/legal guardian's signature. For continued use of a medication that was prescribed as a result of an emergency situation, informed consent must be obtained within 72 hours.

#### N. If the child/adolescent has discontinued the medications for a period of 90 days, a new informed consent must be completed. The discussion with the parent/legal guardian in this situation should include a review of the potential side effects of a discontinuance of psychotropic medications and a consideration of the current willingness and desire of the youth to follow the current treatment plan should be made.

#### O. If a person is seen at the same provider agency under contract with DBHDD, but by a different medical practitioner to prescribe the same medications that the previous medical practitioner prescribed, a new informed consent form is not required.

#### P. If the youth's care is enrolled with a new agency under contract with DBHDD, a new informed consent for medication treatment must be obtained. The new prescriber must verify that the parent/legal guardian continues to consent to treatment with the medication(s) and the prescriber has addressed any current questions or concerns.
State of Georgia, Department of Behavioral Health and Developmental Disabilities
Informed Consent for Psychotropic Medication Treatment for Children and Adolescents

I have discussed the following information with my youth's behavioral health medical practitioner for each medication listed below:

- The diagnosis and target symptoms for the medication recommended
- The possible benefits/intended outcome of treatment, and as applicable, all available procedures involved in the proposed treatment
- The possible risks and side effects
- The possible alternatives
- The possible results of not taking the recommended medication
- The possibility that the medication dose may need to be adjusted over time, in consultation with my youth's behavioral health medical practitioner
- My right to actively participate in the treatment by discussing medication concerns or questions with the behavioral health medical practitioner
- My right to revoke consent for medication at any time unless the use of medications is court ordered.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Diagnosis</th>
<th>Symptoms Targeted with Medication*</th>
<th>Medication Status</th>
<th>How Discussed</th>
<th>Parent/Guardian Initials &amp; Date**</th>
<th>Physician or Designee Initials &amp; Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>In Person</td>
<td>Initials:</td>
<td>Initials:</td>
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<td></td>
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<td></td>
<td>Date:</td>
<td>Date: Time:</td>
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<td></td>
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<td>In Person</td>
<td>Initials:</td>
<td>Initials:</td>
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<td>Date:</td>
<td>Date: Time:</td>
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<td>In Person</td>
<td>Initials:</td>
<td>Initials:</td>
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<td></td>
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<td></td>
<td>Date:</td>
<td>Date: Time:</td>
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<td></td>
<td>In Person</td>
<td>Initials:</td>
<td>Initials:</td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Date:</td>
<td>Date: Time:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I understand the medication(s) listed above are necessary and potentially helpful for my child's mental illness.

Off-label medication use (not FDA approved) and black box warnings have been clearly explained to me by the prescribing physician or his/her designee.

Parent/Legal Guardian Printed Name ___________________________ Signature __________
Initials ___________________________ Physicians or Designee Printed Name ___________________________ Signature __________
Witness Name ___________________________ Signature __________

*Target symptoms refer to specific symptoms associated with a diagnosis, such as triphasic, hallucinations, impulsivity
** Initials must sign and date within 90 days.

I REVOKE MY CONSENT: By signing below I am communicating that I hereby revoke the informed consent and am aware of the potential risks including the potential for involuntary administration of medication if it is considered necessary to maintain my safety or the safety of others.

Parent/Legal Guardian Printed Name ___________________________ Signature __________
Initials ___________________________ Staff Witness Printed Name ___________________________ Signature __________
Date ___________________________
Appendix B: DBHDD Psychotropic Medication Utilization Parameters for Severely Emotionally Disturbed (SED) Children and Adolescents

Psychotropic Medication Utilization Parameters for Severely Emotionally Disturbed (SED) Children and Adolescents

Developed by:

Georgia Department of Behavioral Health and Developmental Disabilities
Psychotropic Medication Utilization Parameters for SED Children and Adolescents

Introduction and General Principles

The use of psychotropic medications by children and adolescents is an issue confronting parents, other caregivers, and health care professionals across the United States. Prescription of these medications has become more widespread in recent years, and in many cases children are prescribed psychotropics by their primary care physicians without concomitant psychiatric consultation. Severely emotionally disturbed (SED) youth, particularly those in state care, have multiple needs, including those related to emotional or psychological stress. SED youth typically have experienced abusive, neglectful, or chaotic care taking environments. Establishment of rapport is often difficult, and these youth often present complicated diagnostic and treatment planning issues. SED youth may reside in areas of the state where child psychiatrists are not readily available. Similarly, caregivers and health providers may be faced with critical situations that require immediate decisions about the care to be delivered. For these and other reasons, a need exists for treatment parameters regarding the appropriate use of psychotropic medications.

Because of the complex issues involved in the lives of SED youth, it is important that a comprehensive evaluation be performed before beginning treatment for a mental or behavioral disorder. Except in the case of an emergency, a child should receive a thorough health history, psychosocial assessment, mental status exam, and physical exam before the prescribing of psychotropic medication. Psychological testing may be particularly useful in clarifying a diagnosis and informing appropriate treatment. The physical assessment should be performed by a physician or another healthcare professional qualified to perform such an assessment. The mental health assessment should be performed by an appropriately qualified mental health professional with experience in providing care to youth. The youth’s symptoms and functioning should be assessed across multiple domains, and the assessment should be developmentally appropriate and culturally sensitive. It is very important that information about the child’s history and current functioning be made available to the treating physician in a timely manner, either through an adult who is well-informed about the youth or through a comprehensive medical record.

The role of nonpharmacological interventions should be considered before beginning a psychotropic medication, except in urgent situations not limited to suicidal ideation, psychosis, self injurious behavior, and physical aggression that is acutely dangerous to others, or severe impulsivity endangering the youth or others. Given the unusual stress and change in environmental circumstances associated with SED youth, counseling or psychotherapy should generally begin before or concurrent with prescription of a psychotropic medication. Patient and caregiver education about the mental disorder, treatment options (nonpharmacological and pharmacological), treatment expectations, and potential side effects provided through informed consent by the prescribing practitioner should occur before and during the prescription of psychotropic medications.
It is recognized that many psychotropic medications do not have Food and Drug Administration (FDA) approved labeling for use in children. The FDA has a statutory mandate to determine whether pharmaceutical company sponsored research indicates that a medication is safe and effective for those indications in which it has been studied by the manufacturer. The FDA also assures that information in the approved product labeling is accurate, and limits the manufacturer’s marketing to the information contained in the approved labeling. The FDA does not regulate physician and other health provider practice. In fact, the FDA has stated that it does “not limit the manner in which a practitioner may prescribe an approved drug.” Studies and expert clinical experience often support the use of a medication for an “off-label” use. Physicians should utilize the available evidence, expert opinion, their own clinical experience, and exercise their clinical judgment in prescribing what they feel is best for each individual youth. “Off-label” medication use should be clearly explained to the youth and his/her parent or legal guardian when obtaining informed consent. The practitioner always documents the rationale for choosing to prescribe off label medication in the medical record of the consumer.
General principles regarding the use of psychotropic medications in SED children include:

• A DSM-IV psychiatric diagnosis should be made before the prescribing of psychotropic medications.

• Assessment of the youth's living situation/caregiver specifically for likelihood of adherence to the prescribed medication regimen.

• Clearly defined target symptoms for the use of psychotropic medications should be identified and documented in the medical record and on the informed consent paperwork at the time of, or before beginning, treatment with a psychotropic medication. These target symptoms should be assessed at each clinic visit with the youth and caregiver. Whenever possible, recognized clinical rating scales (clinician, youth, or caregiver assessed, as appropriate) or other measures should be used to quantify the response of the youth's target symptoms to treatment and the progress made toward treatment goals.

• In making a decision regarding whether to prescribe a psychotropic medication for a specific child, the clinician should carefully consider potential side effects, including those that are uncommon but potentially severe. The clinician should take into account information from the youth’s medical history that may support or contraindicate the use of medication with potentially severe side effects. An appropriate risk-benefit analysis should be performed by the prescribing physician, and discussed with the patient and his/her parent or legal guardian, before beginning pharmacotherapy.

• Except in the case of emergency, defined as imminent risk of harm to self or others, informed consent should be obtained from the appropriate party(ies) before beginning psychotropic medication. Informed consent to treatment with psychotropic medication entails informing the appropriate party(ies) of the diagnosis, expected benefits and risks of treatment, including common side effects, discussion of laboratory findings, and uncommon but potentially severe adverse effects. Alternative treatments, the risks associated with no treatment, and the overall potential benefit to risk ratio of treatment should also be discussed.

• In the event that a youth is uncooperative and does not assent to the use of psychotropic medication in the treatment process, it is important that the medical practitioner consider means by which the youth can be further engaged in the treatment process. This situation presents an opportunity for the medical practitioner to recognize that the assent of the youth will likely lead to a more positive clinical outcome, and that the medical practitioner and youth/family share decision making as well as responsibility for positive treatment outcomes.

• Throughout the time psychotropic medication is administered, the presence or absence of medication side effects should be documented in the youth’s medical record at each visit. Clinicians should ask the youth and the caregiver what side effects the youth is experiencing.

• Appropriate monitoring of indices such as BMI, growth charts, blood pressure, abnormal involuntary movements (use of AIMS) and laboratory findings should be documented.
• Treatment with one psychotropic medication (monotherapy) for a given disorder or specific target symptoms should usually be attempted before additional medications are prescribed (polypharmacy). The clinician should document the rationale for deciding to use polypharmacy.

• Doses should usually be started low and titrated carefully as needed;

• Only one medication should be changed at a time, unless a clinically appropriate reason to do otherwise is documented in the medical record. (Note: starting a new medication and beginning the dose taper of a current medication is considered one medication change);

• The frequency of clinician follow-up with the patient should be appropriate for the severity of the youth's condition and adequate to monitor response to treatment, including symptoms, behavior, function, and potential medication side effects. Titration to the minimum effective dose should be an active goal of any pharmacologic intervention.

• In depressed youth, the potential for emergent suicidality should be carefully evaluated and monitored, and the clinician should inform the caregiver of this potential and ask the caregiver to report any symptoms.

• If the prescribing clinician is not a child psychiatrist, referral to or consultation with a child psychiatrist, or a general psychiatrist with significant experience in treating children, should occur if the child's clinical status has not experienced meaningful improvement within a timeframe that is appropriate for the child's clinical response and the medication regimen being used.

• Before adding additional psychotropic medications to a regimen, the child should be assessed for adequate medication adherence, accuracy of the diagnosis, the occurrence of comorbid disorders (including substance abuse and general medical disorders), and the influence of psychosocial stressors.

• If a medication is being used in a child for a primary target symptom of aggression associated with a DSM-IV nonpsychotic diagnosis (e.g., conduct disorder, oppositional defiant disorder, intermittent explosive disorder), and the behavior disturbance has been in remission for six months, then serious consideration should be given to slow tapering and discontinuation of the medication. If the medication is continued in this situation, the necessity for continued treatment should be evaluated and the rationale documented at a minimum of every six months.

• The clinician should clearly document care provided in the child's medical record, including history, mental status assessment, physical findings (when relevant), impressions, adequate laboratory monitoring specific to the drug(s) prescribed at intervals required specific to the prescribed drug and potential known risks, medication response, presence or absence of side effects, treatment plan, and intended use of prescribed medications. The rationale for any decision to prescribe in a manner that is not standard practice should be documented clearly in the youth's medical record.
Criteria That May Indicate Further Review of a Child’s Clinical Status
The following situations indicate a need for further review of a patient’s case. These parameters do not necessarily indicate that treatment is inappropriate, but they do indicate a need for further review and documentation of findings and relevant clinical decisions. For a child being prescribed a psychotropic medication, any of the following suggests the need for additional review of a patient’s clinical status:

1) Absence of a thorough assessment of DSM-IV diagnosis in the child’s medical record.

2) Four (4) or more psychotropic medications prescribed concomitantly, either within or across medication groups.

3) Prescribing of:
   a) Two (2) or more concomitant antidepressants within the same class
   b) Two (2) or more concomitant antipsychotic medications
   c) Two (2) or more concomitant stimulant medications
   d) Three (3) or more concomitant mood stabilizer medications

*Concomitant prescription of the same stimulant medication in an extended release and immediate-release formulation is regarded as one (1) stimulant medication.

4) The prescribed psychotropic medication is not consistent with appropriate care for the patient’s diagnosed mental disorder or with documented target symptoms usually associated with a therapeutic response to the medication prescribed.

5) Psychotropic polypharmacy for a given mental disorder is prescribed before an adequate trial of psychotropic monotherapy. For the purpose of this document, polypharmacy is defined as the use of two or more medications for the same indication (i.e., specific mental disorder or target symptoms).

6) The psychotropic medication dose exceeds FDA maximum dosage guidelines.

7) Psychotropic medications are prescribed for children of very young age, including children receiving the following medications:
   - Antidepressants: Less than six (6) years of age
   - Antipsychotics: Less than six (6) years of age
   - Psychostimulants: Less than five (5) years of age
   - Polypharmacy: Less than six (6) years of age

8) Prescribing by a primary care provider for a diagnosis other than the following (unless recommended by a psychiatrist consultant):
   - Attention Deficit Hyperactive Disorder (ADHD)
   - Non Co-Occurring anxiety disorders
   - Non Co-Occurring depression
Usual recommended maximum doses of common psychotropic medications

These tables are intended to reflect usual maximum doses of commonly used psychotropic medications. These doses represent usual daily maximum doses, and are intended to serve as a guide for clinicians. The tables are not intended to serve as a substitute for sound clinical judgment in the care of individual patients, and individual patient circumstances may dictate the need for the use of higher doses in specific patients. In these cases, careful documentation of the rationale for the higher dose should occur, and careful monitoring of response to treatment should be observed and documented.

Not all medications prescribed by clinicians for psychiatric diagnoses in children and adolescents are included below. However, in general, medications not listed do not have adequate efficacy and safety information available to support a usual maximum dose recommendations for youth.

### Antidepressants/Anxiolytics

<table>
<thead>
<tr>
<th>Antidepressants/Anxiolytics</th>
<th>Usual Maximum Dose per Day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Children Age 6-11</strong></td>
</tr>
<tr>
<td>Citalopram</td>
<td>40 mg</td>
</tr>
<tr>
<td>Escitalopram (3)</td>
<td>20 mg</td>
</tr>
<tr>
<td>Fluvoxamine (2, 3)</td>
<td>200 mg</td>
</tr>
<tr>
<td>Fluoxetine (4)</td>
<td>20 mg</td>
</tr>
<tr>
<td>Paroxetine (3)</td>
<td>(·)</td>
</tr>
<tr>
<td>Sertraline (3)</td>
<td>200 mg</td>
</tr>
<tr>
<td>Venlafaxine</td>
<td>3 mg/kg/d</td>
</tr>
</tbody>
</table>

(1) In general, doses should be started low and titrated slowly while monitoring the patient for improvement in depressive symptoms, potential side effects, or emergent suicidality.

(2) Has FDA approved labeling for treatment of depression in children.

(3) Has FDA approved labeling for treatment of anxiety disorders in children.

(4) Paroxetine is not recommended for use in preadolescents.

### Antipsychotics

<table>
<thead>
<tr>
<th>Antipsychotics</th>
<th>Usual Maximum Dose per Day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Children Age 6-11</strong></td>
</tr>
<tr>
<td>Aripiprazole</td>
<td>15 mg</td>
</tr>
<tr>
<td>Clozapine</td>
<td>300 mg</td>
</tr>
<tr>
<td>Haloperidol</td>
<td>5 mg</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>12.5 mg</td>
</tr>
<tr>
<td>Perphenazine</td>
<td>No data</td>
</tr>
<tr>
<td>Quetiapine</td>
<td>300 mg</td>
</tr>
<tr>
<td>Risperidone</td>
<td>4 mg</td>
</tr>
<tr>
<td>Ziprasidone</td>
<td>No data</td>
</tr>
<tr>
<td>ADHD Medications</td>
<td>Usual Maximum Dose per Day</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td></td>
<td>Children Age 6-11</td>
</tr>
<tr>
<td>Amphetamine</td>
<td>40 mg</td>
</tr>
<tr>
<td>(Mixed amphetamine salts or dextroamphetamine)</td>
<td></td>
</tr>
<tr>
<td>Atomoxetine</td>
<td>1.8 mg/kg/d</td>
</tr>
<tr>
<td>Bupropion</td>
<td>6 mg/kg/d</td>
</tr>
<tr>
<td>Clonidine</td>
<td>0.4 mg</td>
</tr>
<tr>
<td>Dexamethasoneiodate</td>
<td>20 mg</td>
</tr>
<tr>
<td>Guanfacine</td>
<td>4 mg</td>
</tr>
<tr>
<td>Imipramine</td>
<td>5 mg/kg/day</td>
</tr>
<tr>
<td>Methylphenidate</td>
<td>60 mg</td>
</tr>
<tr>
<td>(72 mg with Concerta only)</td>
<td></td>
</tr>
<tr>
<td>Methylphenidate patch</td>
<td>82.5 mg patch (30 mg dose delivered)</td>
</tr>
<tr>
<td>Nortriptyline</td>
<td>3 mg/kg/day</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mood Stabilizers</th>
<th>Usual Maximum Dose per Day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Children Age 6-11</td>
</tr>
<tr>
<td>Carbamazepine</td>
<td>7 mg/kg/day</td>
</tr>
<tr>
<td>(1)</td>
<td></td>
</tr>
<tr>
<td>Lamotrigine</td>
<td>15 mg/kg/d (200 mg)</td>
</tr>
<tr>
<td>(1)</td>
<td></td>
</tr>
<tr>
<td>Lithium</td>
<td>30 mg/kg/day</td>
</tr>
<tr>
<td>(1)</td>
<td></td>
</tr>
<tr>
<td>Valproic acid (Divalproex)</td>
<td>20 mg/kg/day</td>
</tr>
<tr>
<td>(1) Maximum daily dose typically determined by drug serum concentration (Cs) and individual patient tolerability.</td>
<td></td>
</tr>
</tbody>
</table>
Appendix C: Changes to DBHDD Medication Utilization Parameters Recommended by Child Psychiatrist Workgroup

Criteria That May Indicate Further Review of a Child’s Clinical Status

1. Absence of a thorough assessment of DSM-IV diagnosis in the child’s medical record.  
   Discussion: None

2. Four (4) or more psychotropic medications prescribed concomitantly, either within or across medication groups.  
   Discussion: Majority comments that this is fine as is, one comment that the number should increase from 4 to 5.

3. Prescribing of  
   a. Two (2) or more concomitant antidepressants within the same class  
      Discussion: Majority agreement this is fine as written, but with the addition that there are subclassifications of antidepressants (e.g., SSRIs, SNRIs, TCAs, and other), and that concomitant use of 2 medications from different subclasses should not trigger review, but use of 2 medications within the same class should.
   b. Two (2) or more concomitant antipsychotic medications  
      Discussion: Majority opinion that this is fine as written, but that this should not include PRN use, and should accommodate for injectable plus oral form of same medication, particularly when used to titrate.
   c. Two (2) or more concomitant stimulant medications  
      Discussion: Majority opinion that this is fine as written. The group liked the additional note that says to treat an immediate release and extended release stimulant of the same brand as one medication.
   d. Three (3) or more concomitant mood stabilizer medications  
      Discussion: Majority agreement that 2 mood stabilizers would be reasonable as long as mood stabilizers used for seizure control were not counted against the total.

4. The prescribed psychotropic medication is not consistent with appropriate care for the patient’s diagnosed mental disorder or with documented target symptoms usually associated with a therapeutic response to the medication prescribed.  
   Comments: One comment “reads well,” but question about who identifies target symptoms; discussion that the psychiatrist performs that duty.

5. Psychotropic polypharmacy for a given mental disorder is prescribed before an adequate trial of psychotropic monotherapy. For the purpose of this document, polypharmacy is defined as the use of two or more medications for the same indication
(i.e., specific mental disorder or target symptoms).
Comments: Comments that inpatient settings need to be treated differently than outpatient, polypharmacy as an initial trial could be more common and appropriate in inpatient settings. Majority opinion was that inpatient hospitalization (not PRTFs or CCIs) should have some leeway to allow for polypharmacy without warranting additional clinical documentation.

6. The psychotropic medication dose exceeds FDA maximum dosage guidelines.
Comments: be explicit that the dosage guidelines are what FDA publishes by age group (e.g. use guidelines for adults with adult populations, guidelines for children with child populations). If no FDA guidelines are available, use dosage guidelines included in the Medication Utilization Parameters.

7. Psychotropic medications are prescribed for children of very young age, including children receiving the following medication:
   a. Antidepressants: less than six (6) years of age
      Comments: No change.
   b. Antipsychotics: less than six (6) years of age
      Comments: No change.
   c. Psychostimulants: less than five (5) years of age
      Comments: Down to age 4.
   d. Polypharmacy: less than six (6) years of age
      Comments: No change.

8. Prescribing by a primary care provider for a diagnosis other than the following (unless recommended by a psychiatrist consultant): ADHD, non co-occurring anxiety disorders, non co-occurring depression
Discussion: None
Usual Recommended Maximum Doses of Common Psychotropic Medications
Antidepressants/Anxiolytics*

<table>
<thead>
<tr>
<th>Drug</th>
<th>Usual Maximum Dose per Day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Children (6-11)</td>
</tr>
<tr>
<td>Citalopram</td>
<td>Unchanged</td>
</tr>
<tr>
<td>Escitalopram</td>
<td>Unchanged</td>
</tr>
<tr>
<td>Fluvoxamine</td>
<td>Decrease to 150 mg</td>
</tr>
<tr>
<td>Fluoxetine</td>
<td>Increase to 40 mg&lt;sup&gt;151&lt;/sup&gt;</td>
</tr>
<tr>
<td>Paroxetine</td>
<td>Unchanged</td>
</tr>
<tr>
<td>Sertraline</td>
<td>Decrease to 100 mg</td>
</tr>
</tbody>
</table>

* Recommended increases to SSRI dosages were made to account for higher doses used in children with anxiety.

<sup>150</sup> Recommendation based on FDA black box warning
<sup>151</sup> Recommended increases for both age groups specifically for use in anxiety disorders
## Antipsychotics

<table>
<thead>
<tr>
<th>Drug</th>
<th>Usual Maximum Dose per Day</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Children (6-11)</td>
<td>Adolescents (12-17)</td>
</tr>
<tr>
<td>Aripiprazole**</td>
<td>Unchanged</td>
<td>Unchanged</td>
</tr>
<tr>
<td>Clozapine</td>
<td>Unchanged</td>
<td>Unchanged</td>
</tr>
<tr>
<td>Haloperidol</td>
<td>Increase to 10 mg</td>
<td>Increase to 20 mg</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>Unchanged</td>
<td>Unchanged</td>
</tr>
<tr>
<td>Perphenazine</td>
<td>Unchanged</td>
<td>Unchanged</td>
</tr>
<tr>
<td>Quetiapine</td>
<td>Unchanged</td>
<td>Unchanged</td>
</tr>
<tr>
<td>Risperidone</td>
<td>Unchanged</td>
<td>Unchanged</td>
</tr>
<tr>
<td>Ziprasidone</td>
<td>Unchanged</td>
<td>Reduce to 160 mg</td>
</tr>
</tbody>
</table>

** When used as an adjunctive medication for treatment of Major Depressive Disorder, or when used for children and adolescents with Autistic Disorder, the maximum dose should be 15 mg.
<table>
<thead>
<tr>
<th>Drug</th>
<th>Usual Maximum Dose per Day</th>
<th>Children (6-11)</th>
<th>Adolescents (12-17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amphetamine (Mixed amphetamine salts or dextroamphetamine)</td>
<td>Change to 0.5 mg per 1 kg/max 40 mg</td>
<td></td>
<td>Change to 0.5 mg per 1 kg/max 40 mg</td>
</tr>
<tr>
<td>Atomoxetine</td>
<td>Unchanged</td>
<td></td>
<td>Unchanged</td>
</tr>
<tr>
<td>Bupropion</td>
<td>Unchanged</td>
<td></td>
<td>Unchanged</td>
</tr>
<tr>
<td>Clonidine</td>
<td>Reduce to 0.3 mg</td>
<td></td>
<td>Unchanged</td>
</tr>
<tr>
<td>Dexmethylphenidate</td>
<td>Unchanged</td>
<td></td>
<td>Unchanged</td>
</tr>
<tr>
<td>Guanfacine</td>
<td>Reduce to 3 mg</td>
<td></td>
<td>Unchanged</td>
</tr>
<tr>
<td>REMOVE Imipramine</td>
<td>REMOVE</td>
<td></td>
<td>REMOVE</td>
</tr>
<tr>
<td>Methlyphenidate</td>
<td>Change to 1 mg per 1 kg/max 72 mg</td>
<td></td>
<td>Change to 1 mg per 1 kg/max 72 mg</td>
</tr>
<tr>
<td>Methylphenidate patch</td>
<td>Unchanged</td>
<td></td>
<td>Unchanged</td>
</tr>
<tr>
<td>REMOVE Nortriptyline</td>
<td>REMOVE</td>
<td></td>
<td>REMOVE</td>
</tr>
<tr>
<td>ADD Lisdexamfetamine</td>
<td>50 mg</td>
<td></td>
<td>70 mg</td>
</tr>
</tbody>
</table>
## Mood Stabilizers

<table>
<thead>
<tr>
<th>Drug</th>
<th>Usual Maximum Dose per Day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Children (6-11)</td>
</tr>
<tr>
<td>Carbamazepine</td>
<td>Unchanged</td>
</tr>
<tr>
<td>Lamotrigine</td>
<td>Unchanged</td>
</tr>
<tr>
<td>Lithium</td>
<td>Unchanged</td>
</tr>
<tr>
<td>Valproic acid</td>
<td>Unchanged</td>
</tr>
<tr>
<td>ADD Oxcarbazepine***</td>
<td>30 mg per 1 kg/ max 1200 mg</td>
</tr>
</tbody>
</table>

*** Not FDA-indicated for treatment of mental illness in adults or children.

Other notes
- Parameters should be updated on a regular schedule to accommodate changes based on additional research data as it becomes available.
- Off-label prescribing of psychotropic medication for children is commonly practiced; dose adjustments are made to account for the child’s age.