ACF Administration for Children and Families	U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Administration on Children, Youth and Families	
	1. Log No: ACYF-CB-IM-12-03	**2. Issuance Date:** 04-11-2012
	3. Originating Office: Children's Bureau	
	4. Key Words: Oversight of Psychotropic Medication for Children in Foster Care; Title IV-B Health Care Oversight & Coordination Plan	

INFORMATION MEMORANDUM

To: State, Tribal and Territorial Agencies Administering or Supervising the Administration of Titles IV-B and IV-E of the Social Security Act, Indian Tribes and Indian Tribal Organizations

Subject: Promoting the Safe, Appropriate, and Effective Use of Psychotropic Medication for Children in Foster Care

Purpose: To serve as a resource to State and Tribal title IV-B agencies as they comply with requirements to develop protocols for the appropriate use and monitoring of psychotropic medications in the title IV-B plan. This Information Memorandum (IM) defines the issues surrounding psychotropic medication use by children in foster care, highlights available resources for States to consider when developing their Annual Progress and Services Report (APSR), and encourages increasing access to clinically appropriate screening, assessment, and evidence-based interventions for foster children with mental health and trauma-related needs.

Legal and Related References: Section 422(b)(15) of the Social Security Act (the Act)

Statutory Background:

Recent statutory mandates require States, Territories and Tribes that administer title IV-B, subpart 1 programs to address some of the most pressing issues related to psychotropic medication prescription oversight and monitoring for children in foster care. These include:

- The **Fostering Connections to Success and Increasing Adoptions Act of 2008** (Public Law (P.L.) 110-351) amended title IV-B, subpart 1 of the Social Security act to require State and Tribal[1] title IV-B agencies to develop a plan for ongoing oversight and coordination of health care services for children in foster care, in coordination and consultation with the State title XIX (Medicaid) agency, pediatricians, and other experts in health care, as well as experts in and recipients of child welfare services. The plan must describe how it will ensure a coordinated strategy to identify and respond to the health care needs of children in foster care placements, including mental health and dental health needs, and provide for continuity of

[1] Some Tribes receiving title IV-B funding do not directly operate foster care programs. In these instances, the State agency is responsible for providing foster care services for Tribal children needing such services and for developing the health care oversight and coordination plan.

health care services, which may include establishing a "medical home" for children who are in foster care. The purpose of these requirements is to ensure that children in foster care receive high-quality, coordinated health care services, including appropriate oversight of any needed prescription medicines (section 422(b)(15) of the Act).

- The **Child and Family Services Improvement and Innovation Act** (P.L. 112-34) amended the law by adding to the requirements for the health care oversight and coordination plan. Whereas the law had previously required that the plan address "oversight of prescription medicines," the new provision builds on this requirement by specifying that the plan must include an outline of "protocols for the appropriate use and monitoring of psychotropic medications." In addition, P.L. 112-34 requires that the health care oversight and coordination plan outline "how health needs identified through screenings will be monitored and treated, including emotional trauma associated with a child's maltreatment and removal from home" (section 422(b)(15)(A) of the Act).

  Although not initially mandated by statute, it should be noted that the Children's Bureau (CB) has always encouraged title IV-B agencies to address oversight of psychotropic medications in the plan for ongoing oversight and coordination of health care services since the first guidance on the health care plan was issued in 2009 (see ACYF-CB-PI-09-06 and ACYF-CB-09-07). With the amendments made by P.L. 112-34, it is now a statutory requirement that oversight of psychotropic medications be explicitly addressed in the health care oversight and coordination plan.

  States and Tribes will need to address how they are responding to these new requirements in their Annual Progress and Services Reports (APSRs) which are due on June 30, 2012.

Issue Background:

Prevalence of psychotropic medication use among children in foster care

There has been a steady rise in the use of medication to address children's emotional and behavioral problems over the last decade, even among pre-schoolers.[2] For example, one study found that, in 1996, approximately four percent of youth in the general population received psychotropic medication: almost three times the usage rates reported in 1987.[3]

At this time, there is no comprehensive source of data regarding psychotropic medication usage rates for children and adolescents in child welfare, including data on those in foster care. Rather, existing data: 1) is not current, lagging behind by as much as a decade; 2) is often geographically specific (e.g., from one State); and 3) comes from research conducted on the broader population of children who are involved with child welfare agencies (including children served in their own homes, as well as children who are in foster care). Despite these deficiencies, published studies consistently reveal even higher rates of use for children involved in child welfare than in the general population, with usage rates between 13 and 52

[2] Zito, J.M., Safer, D.J, dosReis, S., Gardner, J.F., Bole, M. & Lynch, F. (2000). Trends in the prescribing of psychotropic medications to preschoolers. *JAMA*, 238(8), 1025-1030.
[3] ZitoJ M, Safer DJ, Sai D et al. (2008). Psychotropic medication patterns among youth in foster care. *Pediatrics,* 121:e157-e163.

percent.[4,5,6,7,8,9,10] Moreover, studies have shown the following with regard to the prevalence of psychotropic drug use and factors influencing the likelihood of use among children in foster care:[11]

- Age: Children in foster care are more likely to be prescribed psychotropic medications as they grow older, with 3.6 percent of two to five year-olds taking psychotropic medication at a given time. This increases to 16.4 percent of 6-11 year olds and 21.6 percent of 12-16 year olds. The likelihood that a child will be prescribed multiple psychotropic medications also increases with age.

- Gender: Males in foster care are more likely to be receiving psychotropic medications (19.6 percent) than their female counterparts (7.7 percent).

- Behavioral Concerns: Children scoring in the clinical range on the Child Behavioral Checklist, a common tool for assessing both internalizing and externalizing behavioral issues among children and youth, are much more likely than those with subclinical scores to receive psychotropic medications.

- Placement Type: Children in the most restrictive placement setting are the most likely to receive psychotropic medications. In group or residential homes, nearly half of the young people are taking at least one psychotropic drug. Additionally, children in more restrictive placement types are more likely to be taking multiple psychotropic medications.

- Geographic Variation: There are also significant geographic variations within and across States in the prevalence of psychotropic use among children in foster care. These varying rates of use cannot be attributed to population differences, suggesting that factors other than clinical need may be influencing the practice of prescribing psychotropic

[4] dosReis, S., Zito, J.M., Safer, D.J., Soeken, K.L. (2001). Mental Health Services for Foster Care and Disabled Youth. American Journal of Public Health, 91(7), 1094-1099.
[5] McMillen JC, Fedoravicius N, Rowe J, Zima BT, Ware N. (2007) A crisis of credibility: Professionals' concerns about the psychiatric care provided to clients of the child welfare system. *Administration & Policy in Mental Health and Mental Health Services Research, 34*:203-12.
[6]Office of the Texas Comptroller. (2007) *Texas Health Care Claims Study: Special Report on Foster Children*. Texas Comptroller of Public Accounts.
[7] Olfson, M, Marcus, S.C., Weissman, M.M., & Jensen, P.S. (2002). National trends in the use of psychotropic medications by children. *Journal of American Child and Adolescent Psychiatry*, 41(5), 514-521.
[8] Leslie, LK; Raghavan, R; Zhang, J; & Aarons, GA. (2010). Rates of psychotropic medication use over time among youth in child welfare/child protective services. *Journal of Child and Adolescent Psychopharmacology.* 20(2):135.
[9] Zima, B. T., Hurlburt, M. S., Knapp, P., Ladd, H., Tang, L., Duan, N. et al. (2005). Quality of publicly-funded outpatient specialty mental health care for common childhood psychiatric disorders in California. *Journal of the American Academy of Child Adolescent Psychiatry, 44*(2), 130-144.
[10] Ferguson, D.G, Glesener, D.C. & Raschick, M. (2006). Psychotropic Drug Use with European American and American Indian Children in Foster Care. *Journal of Child and Adolescent Psychopharmacology*, 16(4), 474-481.
[11] Raghavan, R; Zima, BT; Anderson, RM; Leibowitz, AA; Schuster, MA; & Landsverk, J. (2005). Psychotropic medication use in a national probability sample of children in the child welfare system. *Journal of child and adolescent psychopharmacology*. 15(1):97.

medications.[12] In a national study, rates of medication use varied 0-40 percent, representing a 40-fold variation across catchment areas.[13] It should be noted, however, that while these data raise concerns about medication overuse, there is also data to suggest that some foster children (e.g., those in rural areas) may actually be prescribed at lower than normal rates and this suggests they may not have adequate access to needed psychiatric care.[14]

Social-emotional, behavioral, and mental health needs of children with child welfare involvement

Children who come to the attention of the child welfare system have disproportionally high rates of social-emotional, behavioral, and mental health challenges.[15] These social-emotional, behavioral and mental health concerns include the following:

- 23 percent of children age 17 and under who have experienced maltreatment have behavior problems requiring clinical intervention. Clinical-level behavior problems are almost three times as common among this population as among the general population. Both internalizing problems (e.g., depression, anxiety, being withdrawn) and externalizing problems (e.g., aggression, delinquency) are common in children who have experienced maltreatment. Among children who enter foster care, approximately one third scored in the clinical range for behavior problems on the Child Behavior Checklist.
- 35 percent of children age 17 and under who have experienced maltreatment demonstrate clinical-level problems with social skills – more than twice the rate of the general population.
- Children in foster care are more likely to have a mental health diagnosis than other children. In a study of foster youth between the ages of 14 and 17, [16] 63 percent met the criteria for at least one mental health diagnosis at some point in their life. The most common diagnoses were Oppositional Defiant Disorder/Conduct Disorder, Major Depressive Disorder/Major Depressive Episode, Attention Deficit/Hyperactivity Disorder, and Posttraumatic Stress Disorder.

[12] Raghavan, R; Gyanesh, L; Kohl, P; & Hamilton, B. (2010). Interstate variations in psychotropic medication use among a national sample of children in the child welfare system. *Child Maltreatment.* 15(2): 121-131.
[13]Leslie, L K., Raghavan, R, Hurley, M, Zhang, J, Landsverk, J, Aarons, G. (2011) Investigating geographic variation in use of psychotropic medications among youth in child welfare. *Child Abuse & Neglect, 35(5):*333-42.
[14] Zima, B.T., Bussing, R., Crecelius, G.M., Kaufman, A. & Belin, T.R. (1999) Psychotropic medication use among children in foster care: Relationship to severe psychiatric disorders. American Journal of Public Health, 889(11), 1732-1735.
[15] The *National Survey of Child and Adolescent Well-Being* (NSCAW) is a longitudinal study required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 overseen by the Administration on Children and Families. It is a key source of information about the social and emotional well-being of children who have experienced maltreatment, including information on rates of psychotropic medication use.
[16] White, CR; Havalchak, A; Jackson, L; O'Brien, K; & Pecora, PJ. (2007). Mental Health, Ethnicity, Sexuality, and Spirituality among Youth in Foster Care: Findings from The Casey Field Office Mental Health Study. Casey Family Programs.

- According to one study, by the time they are age 17, 62 percent of youth in foster care will exhibit both the symptoms of a mental health disorder and the symptoms of trauma.[17]
- Although they make up only three percent of the Medicaid population under age 18, children in foster care account for 32 percent of the recipients of behavioral health services in this age group.[18]

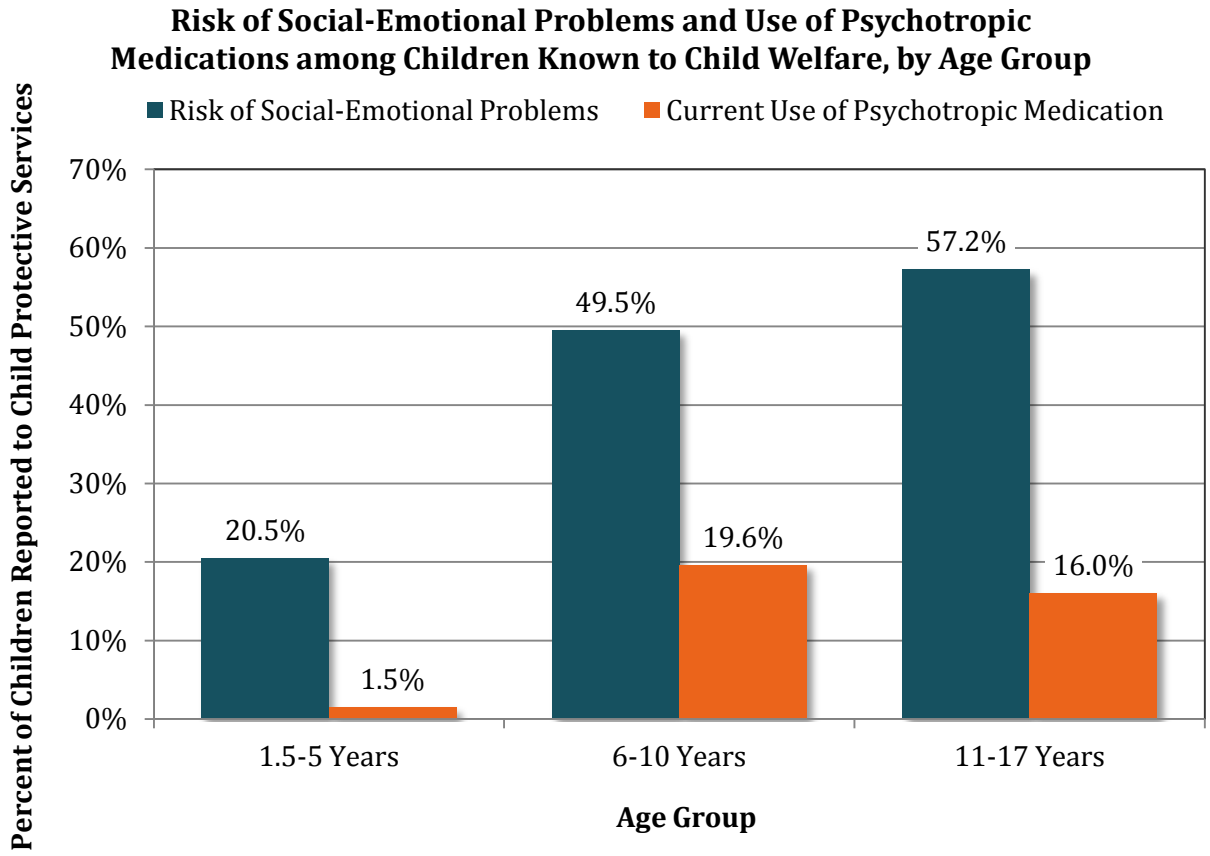
These data clearly show that the broader group of children who experience maltreatment and come to the attention of a child welfare agency (of which children in foster care are a subset) have emotional and behavioral problems that derail normal development, hinder healthy functioning, and impede the achievement of permanency.

Appropriateness of psychotropic medication use among children in foster care

Although numerous studies have demonstrated that the rates of psychotropic medication prescriptions are high among children in foster care, these rates, at least in part, may reflect increased levels of emotional and behavioral distress. Figure I (below) demonstrates the high level of mental health needs among children involved with the child welfare system and illustrates the relationship between the clinical need and the use of psychotropic medications across three age groups. In addition, Figure 2 shows that, with the exception of residential treatment settings, the rate of psychotropic medication prescription is relatively consistent regardless of whether children were served in their own homes or removed from the home and placed in either kinship care or a foster family home; suggesting that rates of mental health needs and associated use of psychotropic medications are not primarily the result of removing children from their homes.

[17] Griffin, G; McClelland, Holzberg, M; Stolbach, B; Maj, N; & Kisiel, C (In Press). Addressing the impact of trauma before diagnosing mental illness in child welfare. *Child Welfare.*
[18] Center for Health Care Strategies, Inc. (Forthcoming). Analysis of Medicaid Claims Data for 2005.

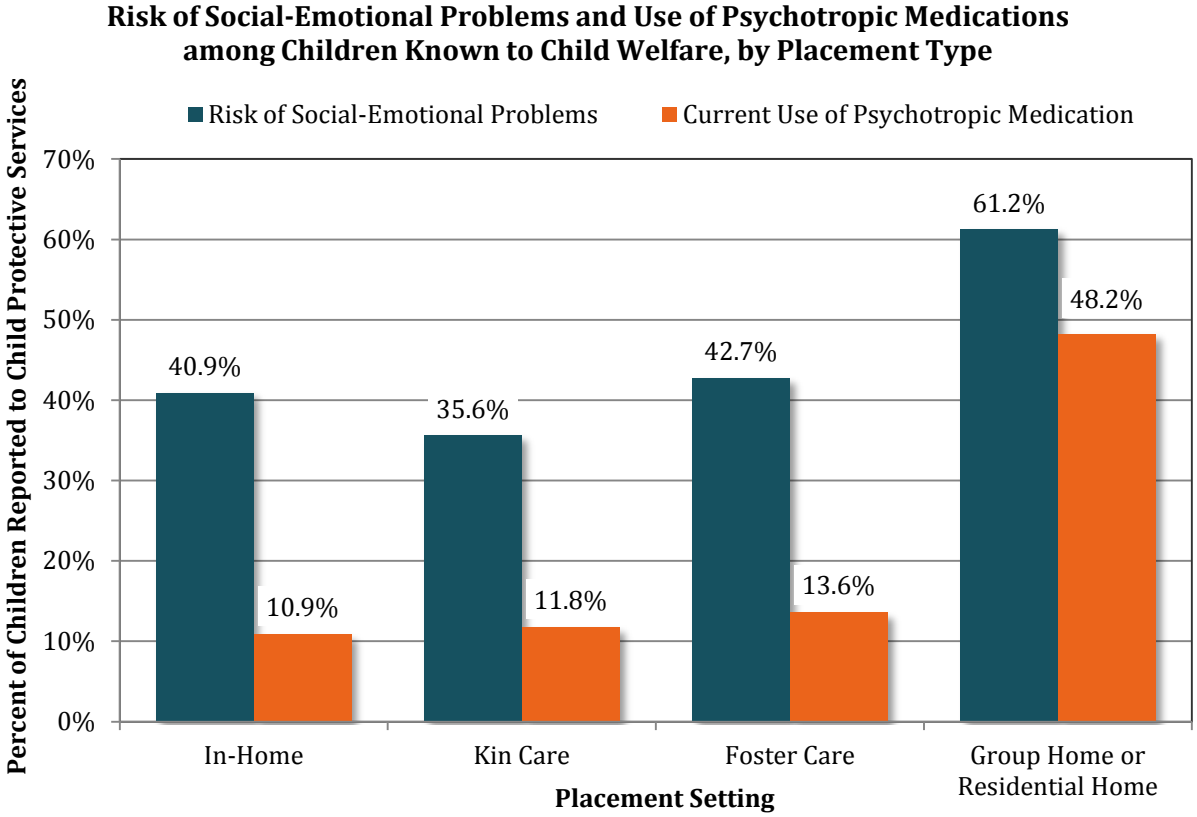
FIGURE 1



Data Source: National Survey of Child and Adolescent Well-Being II (NSCAW II). NSCAW II is a Congressionally required study sponsored by the Office of Planning, Research and Evaluation, Administration for Children and Families (ACF), U.S. Department of Health and Human Services (DHHS).

Risk of social-emotional problems was defined as scores in the clinical range on any of the following standardized measures: Internalizing, Externalizing or Total Problems scales of the Child Behavior Checklist (CBCL: administered for children 1.5 to 18 years old), Youth Self Report (YSR; administered to children 11 years old and older), or the Teacher Report From (TRF; administered for children 6 to 18 years old); the Child Depression Inventory (CDI; administered to children 7 years old and older); or the PTSD section Intrusive Experiences and Dissociation subscales of the Trauma Symptoms Checklist (administered to children 8 years old and older).

FIGURE 2



Data Source: National Survey of Child and Adolescent Well-Being II (NSCAW II). NSCAW II is a Congressionally required study sponsored by the Office of Planning, Research and Evaluation, Administration for Children and Families (ACF), U.S. Department of Health and Human Services (DHHS).

Risk of social-emotional problems was defined as scores in the clinical range on any of the following standardized measures: Internalizing, Externalizing or Total Problems scales of the Child Behavior Checklist (CBCL: administered for children 1.5 to 18 years old), Youth Self Report (YSR; administered to children 11 years old and older), or the Teacher Report From (TRF; administered for children 6 to 18 years old); the Child Depression Inventory (CDI; administered to children 7 years old and older); or the PTSD section Intrusive Experiences and Dissociation subscales of the Trauma Symptoms Checklist (administered to children 8 years old and older).

The graphics above demonstrate that many children in foster care have mental health challenges requiring intervention, which may include the appropriate use of psychopharmacological treatments as part of a comprehensive treatment approach. Unfortunately, research on the safe and appropriate pediatric use of psychotropic medications lags behind prescribing trends.[19] There is even less evidence of the effectiveness of pharmacologic interventions for the treatment of trauma-related symptoms in children.[20] In the absence of such research, it is not possible to

[19] Jensen, P.S., Bhatara, V.S., Vitiello, B., Hoagwood, K., Feil, M., & Burke, L.B. (1999). Psychoactive Medication Prescribing Practices for U.S. Children: Gaps Between Research and Clinical Practice. Journal of the American Academy of Child & Adolescent Psychiatry, 38(5), 557-565.

[20] Wethington, H.R., Hahn, R.A., Fuqua-Whitley, D.S., Sipe, T.A., Crosby, A.E., Johnson, R.L., Liberman, A.M., Mos´cicki, E., Price, L.N., Tuma, F.K., Kalra, G., Chattopadhyay, S.K, & Task Force on Community Preventive Services. (2008). The Effectiveness of Interventions to Reduce Psychological Harm from Traumatic Events Among Children and Adolescents: A Systematic Review. *American Journal of Preventative Medicine*, 35(3), 287–313.

know all of the short- and long-term effects, both positive and negative, of psychotropic medications on young minds and bodies.

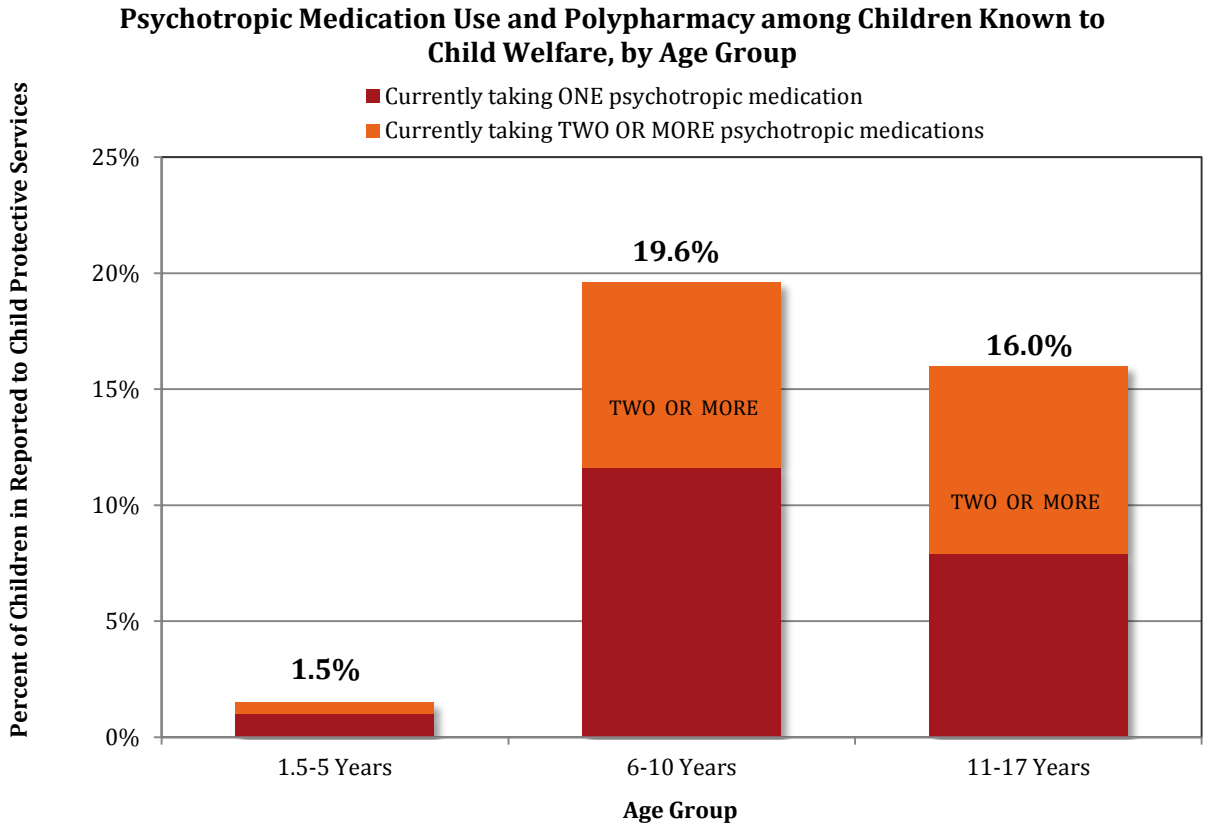
Patterns that may signal that factors other than clinical need are impacting the prescription of psychotropic medications are referred to as "outlier practices" or "red flags." Practices that may be of concern include instances where children are prescribed too many psychotropic medications, too much medication, or at too young an age: too many, and too much, too young.

- Too many: Children with histories of maltreatment, including those in foster care, often present with complex trauma-related and mental health needs, often demonstrating multiple diagnoses at one time (i.e., co-morbidity). To treat the multiple mental and behavioral health symptoms that a child may exhibit, more than one drug – and often more than one type of medication–are prescribed. There is, however, scant evidence of the effectiveness of using multiple psychotropic medications at once (polypharmacy). No research supports the use of five or more psychotropic drugs.

  Despite the lack of supporting evidence and the potential for adverse effects (e.g., side effects, drug interactions, metabolic effects, and potential that some medications may alter nervous system development), polypharmacy is on the rise. A 2002 study of children in the general population showed an increase of greater than 600 percent (0.03 per 100 to 0.23) in the rate of prescription of more than one psychotropic medication at a time.[21] A 2008 study of children in foster care taking psychotropic medication found 21.3 percent are receiving mono-therapy (one class of psychotropic medication), 41.3 percent are taking three or more classes of psychotropic medications, 15.4 percent are taking medication from four or more classes, and 2.1 percent are taking five or more classes of psychotropic drugs.[22] These trends are further reflected in data from the National Survey of Child and Adolescent Well-Being, which shows the proportion of children reported to child protective services who are receiving two or more psychotropic medications at once (see Figure 3 below).

[21] Olfson, M, Marcus, S.C., Weissman, M.M., & Jensen, P.S. (2002). National trends in the use of psychotropic medications by children. *Journal of American Child and Adolescent Psychiatry*, 41(5), 514-521.
[22] Zito, JM; et al., (2008). Psychotropic medication patterns among youth in foster care. *Pediatrics*. 121(1): e157.

FIGURE 3



Data Source: National Survey of Child and Adolescent Well-Being II (NSCAW II). NSCAW II is a Congressionally required study sponsored by the Office of Planning, Research and Evaluation, Administration for Children and Families (ACF), U.S. Department of Health and Human Services (DHHS).

Prescription patterns that may be of concern in this category include: children taking three or more medications at a time; prescription of two or more medications in the same class for more than 30 days, and prescribing multiple psychotropic medications before testing the effectiveness of a single medication (polypharmacy before monopharmacy).

- Too Much: Another potential outlier practice or "red flag" that may be cause for concern is prescriptions in dosages that exceed recommendations. Because very few psychotropic medications are tested on children, research-based guidelines for medication dosages exist for very few psychotropic medications prescribed to children. Prescription labeling by the Food and Drug Administration (FDA) is one way that dosage guidelines are established, however, the majority of pediatric psychotropic use is off-label.[23] This means that even though the drug can legally be used, the product label does not specify that it was approved for a particular age group or particular treatment application. [24]

[23] Roberts R., Rodriguez W., Murphy D., and Crescenzi T.(2003). *Pediatric drug labeling*. *JAMA*, 290, 905-911.

[24] FDA regulations allow prescription of approved medications for other than their approved indications.

In the absence of a robust research base and evidence-based prescription guidelines, some jurisdictions have adopted consensus-based approaches that attempt to define safe and effective use of psychotropic medications for a variety of mental health diagnoses found in children and adolescents. One such set of practice parameters was developed by the State of Texas, with guidance from an expert panel, to be used as a resource for physicians and other clinicians.[25] Other States have implemented systems that require prior authorization and, in some cases, mandatory second opinions in an effort to ensure appropriate use of psychotropic medication for foster children (including proper dosage).[26]

Until all drugs are properly studied in the populations for which they are being used, the lack of specific evidence-based recommendations reinforces the need for close supervision and monitoring for patients receiving psychotropic medication for off-label uses.[27]

- Too Young: According to a study by Zito and colleagues (2000), between 1991-1995 there was a 50 percent increase in the rate at which preschool children (age 2-4) were prescribed psychotropic medications, with 1.5 percent of preschoolers being prescribed stimulants or other psychotropic medication.[28] A 2011 report from a Government Accountability Office (GAO) examining psychotropic use in five states found foster children have higher rates of psychotropic use than other children enrolled in the Medicaid program.[29] Specifically, the GAO study found that 0.3 to 2.1 percent of children in foster care under one year old were prescribed potentially psycho-active medications (most commonly antihistamines and benzodiazepines) compared to a 0.1 to 1.2 percent of children not in foster care.

  Psychotropic medication use with young children is of special concern since this population may be especially vulnerable to adverse effects, necessitating careful management and oversight.[30]

Beyond "too many, too much, too young", the dramatic increase in the use of antipsychotic medication for children and adolescents over the past two decades has also raised concern. While prescription rates have risen across-the-board, a recent 16-State study found that foster children received antipsychotic medications at a rate almost nine times that of other children

---

[25] Retrieved from: http://www.dshs.state.tx.us/mhprograms/pdf/PsychotropicMedicationUtilizationParameters FosterChildren.pdf)

[26] Naylor, M.W., Davidson, C., Ortega-Piron, D.J., Bass, A., Guitierrez, A, Hall, A. (2007). Psychotropic medication management for youths in state care: Pharmacoepidemiology and policy considerations. *Child Welfare*, 86(5):175-192.

[27] Zito, J.M., Derivan, A.T., Kratochvil, C.J., Safer, D.J., Fegert, J.M., & Greenhill, L.L. (2008), Child and Adolescent Psychiatry and Mental Health. *Off-label psychopharmacologic prescribing for children: History supports close clinical monitoring*.

[28] Zito, J.M., Safer, D.J, dosReis, S., Gardner, J.F., Bole, M. & Lynch, F. (2000). Trends in the prescribing of psychotropic medications to preschoolers. *JAMA*, 238(8), 1025-1030.

[29] U.S. Government Accountability Office. *Foster Children: HHS Guidance Could Help States Improve Oversight of Psychotropic Prescriptions*. Washington, D.C.: General Accountability Office; 2011. GAO-12-201. Retrieved from: http://www.gao.gov/products/GAO-12-270T

[30] Gleason M.M., Egger HL, Emslie G.J., Greenhill L.L., Kowatch RA, Lieberman AF, Luby J.L., Owens J, Scahill L.D., Scheering, M.S., Stafford B, Wise B, Zeanah C.H.(2007). Psychopharmacological treatment for very young children: Contexts and guidelines. *Journal of the American Academy of Child and Adolescent Psychiatry*, 46(12):1532-1572.

covered by Medicaid even though they represent only three percent of those covered. [31] Although this study was not able to explicitly examine the relationship between mental health diagnosis and prescribing patterns, other published research suggests that psychotropic drugs are being overused to manage emotional problems and disruptive behavior that might better be addressed by non-pharmacological treatment approaches.

When used appropriately, antipsychotic medications may provide a legitimate treatment option for some children in foster care. However, it is generally recommended that prescription of antipsychotic medications be closely monitored, especially when they are prescribed for more than two years and when they are used without a diagnosis of schizophrenia, bipolar disorder, or psychosis.

In summary, while medication can be an important component of a comprehensive response to the complex mental health needs of children in foster care, current use of psychotropic medications among children in foster care at times may exceed practice standards that are supported by empirical research. The following factors may play a role in these patterns of psychotropic medication use in foster children: [32]

- Insufficient State oversight and monitoring of psychotropic medication use;
- Gaps in coordination and continuity of medical and mental health care across public health and social service systems involved with affected children and their families;
- Provider shortages, especially of board-eligible and board-certified child and adolescent psychiatrists, in some geographic areas (e.g., rural areas); and
- Lack of access to effective non-pharmacological treatments in outpatient settings.

Strengthened oversight of psychotropic medication use is necessary in order to responsibly and effectively attend to the clinical needs of children who have experienced maltreatment. The processes and practices suggested by this document provide increased opportunities for that oversight for children in foster care.

Practice guidelines related to the development of protocols for the appropriate use and monitoring of psychotropic medication

In the past decade, a variety of practice guidelines have been developed related to the use of psychotropic medication for foster children, including those developed to guide and inform physician prescription practices. Examples include policy statements and guidelines developed

[31] Crystal, S; Olfson, M; Huang, C; Pincus, H; & Gerhard, T. (2009). Broadened use of atypical antipsychotics: Safety, effectiveness, and policy challenges. *Health Affairs,* 28(5):770. (http://content.healthaffairs.org/content/28/5/w770.full.html)

[32] Mackie, T.I., Hyde, J., Rodday, A.M., Dawson, E., Lakshmikanthan, R., Bellonci, C., Schoonover, D.R., and Leslie, L.K. (2011). Psychotropic medication oversight for youth in foster care: A national perspective on state child welfare policy and practice guidelines. Child and Youth Services Review, 33, 2213-2220.

by the American Academy of Child and Adolescent Psychiatry (AACAP)[33], the American Academy of Pediatrics,[34] and prescription parameters developed by the State of Texas[35] (later refined by Crismon and Argo, 2009).[36] These efforts are particularly important given that the majority of physicians responsible for prescribing psychotropic medication to foster children are pediatricians or general psychiatrists without formal training in child and adolescent psychiatry and may not have an abundance of exposure to concerns specific to children in foster care.

Perhaps more directly applicable to title IV-B agencies seeking to improve their monitoring and oversight practices of psychotropic medications are two published guidelines that specifically describe components of comprehensive oversight and management plans for children in child welfare. These include an AACAP position statement [37] and guidelines developed by an expert panel convened by the Reach Institute.[38] In addition, a 2010 survey of State written policies and guidelines related to the oversight of psychotropic medication in foster children identified 10 key components of State oversight protocols,[39] and a study by Naylor, et al. (2007) provides additional considerations concerning consent, oversight and policy issues. [40]

Consistent elements found in more than one set of guidelines cited above include the need for written policies to contain provisions for:

- Comprehensive and coordinated screening, assessment, and treatment planning mechanisms to identify children's mental health and trauma-treatment needs (including a psychiatric evaluation, as necessary, to identify needs for psychotropic medication);
- Informed and shared decision-making (consent and assent) and methods for on-going communication between the prescriber, the child, his/her caregivers, other healthcare providers, the child welfare worker, and other key stakeholders;
- Effective medication monitoring at both the client and agency level;

---

[33] American Academy of Child and Adolescent Psychiatry. The Mental Health Needs of Children in Foster Care, Policies and Best Principles. AACAP website; http://www.aacap.org.

[34] American Academy of Pediatrics. (2002). Health care of young children in foster care. Pediatrics, 109, 536-541.

[35] Texas Department of State Health Services (2007). Psychotropic medication utilization parameters for foster children. Retrieved from http://dshs.state.tx.us/mhprograms/pdf/PsychotropicMedicationUtilizationParametersFosterChildren.pdf

[36] Crismon, M.L., & Argo, T. (2009). The use of psychotropic medication for children in foster care. Child Welfare, 88, 71-100.

[37] AACAP Position Statement on Oversight of Psychotropic Use for Children in State Custody: A Best Principles Guideline. AACAP website only. http://www.aacap.org/galleries/PracticeInformation/FosterCare_BestPrinciples_FINAL.pdf

[38] Romanelli, L.H., Landsverk, J., Levitt, J.M., Leslie, L.K., Hurley, M.M., Bellonci, C. et al. (2009). Best practices for mental health in child welfare: Screening, assessment, and treatment guidelines. Child Welfare, 88(1), 163-188.

[39] Leslie, L.K., Mackie, T., Dawson, E.H., Bellonci, C., Schoonover, D.R., Rodday, A.M., et al. (2010). Multi-state study on psychotropic medication oversight in foster care. Boston, MA: Tufts Clinical Translational Science Institute

[40] Naylor, M., Davidson, C., Ortega-Piron, D., Bass, A, Guitierrez, A., and Hall, A. (2007). Psychotropic medication management for youth in state care: Consent, oversight, and policy considerations. Child Welfare, 86(5), 175.

- Availability of mental health expertise and consultation regarding both consent and monitoring issues by a board-certified or board-eligible Child and Adolescent Psychiatrist (at both the agency and individual case level); and
- Mechanisms for accessing and sharing accurate and up-to-date information and educational materials related to mental health and trauma-related interventions (including information about psychotropics) to clinicians, child welfare staff, and consumers.

A particularly helpful aspect of the AACAP guidelines is the categorization of standards in these areas as Minimal, Recommended, and Ideal – features title IV-B agencies may find helpful as they seek to make decisions about improving their current oversight procedures. This approach to categorization of State practices was used in the recent six-state study by GAO of psychotropic medication use by children in foster care to grade each state monitoring system against AACAP recommendations.

In addition, the AACAP guidelines are based on a core set of clinical practice principals specific to psychiatric and pharmacologic treatment of children in foster care. While many professional organizations have practice standards and guidelines related to work with children involved with child welfare (e.g., National Association of Social Workers (NASW) Standards for Social Work Practice in Child Welfare, the Child Welfare League of America's Standards of Excellence, and the Guiding Principles of Systems of Care), the AACAP guidelines are unique in their application to clinical management of psychotropic medications and may be particularly relevant to States, and Tribes when developing the psychotropic medication oversight and monitoring component of their title IV-B plan.

Each title IV-B agency and its service delivery array is unique, making it impractical and inappropriate for every oversight and monitoring plan to be the same. Factors that may influence how States go about developing their plans may include differences in whether the State is largely urban or rural; whether the child welfare service delivery structure is State- or county-administered; the type of Medicaid reimbursement program in place; the availability of qualified practitioners; the availability of automated information systems; and workforce-related issues. As such, each State will need to carefully assess existing oversight mechanisms and evaluate the options in light of how they fit with its own set of needs and challenges. Similarly, Tribes will need to assess the availability of services and qualified practitioners in their service areas to develop monitoring and oversight protocols appropriate to their unique situations.

It should be highlighted that the development of a comprehensive approach to psychotropic medication oversight requires high levels of collaboration among child welfare agencies, professionals, organizations providing foster care and mental health services, children who are recipients of child welfare services, and their families. Nonetheless, most States that responded to the survey described in the 2010 study by Leslie, et. al, acknowledged significant obstacles to collaboration that made it more difficult to develop feasible and sustainable medication oversight plans. Because title IV-B and Medicaid agencies, pediatricians, and other key health and child welfare experts will need to coordinate in ways they may not have done before, it will also be important to intentionally craft mechanisms to actively engage and involve a broad range of stakeholders.

Federal Initiatives to Encourage the Appropriate Use of Psychotropic Medication:

Because children in foster care are typically involved with multiple service delivery systems, including education, health, mental health, Medicaid, and others, a coordinated, multi-system approach is necessary to meaningfully improve outcomes for this population. The Department of Health and Human Services (HHS) is working to facilitate cross-system collaborations for the purposes of promoting improved behavioral health diagnosis, treatment, service delivery and service tracking for children in foster care.

Toward this goal, HHS has identified concrete actions in two areas: (1) increasing oversight and monitoring of psychotropic medications; and (2) expanding the use of evidence-based screening, diagnosis, and treatment of social-emotional, behavioral, and mental health issues among children who have experienced abuse or neglect. Below is a partial list of activities to be undertaken addressing the use of psychotropic medication among children in foster care.

Increased oversight and monitoring: Across the nation, practices related to the oversight and monitoring of psychotropic medications for foster children vary widely, and experts agree that greater controls are needed to ensure safe and appropriate use of psychotropic medications. HHS efforts include the development of a comprehensive Departmental plan focused on ensuring the safe, appropriate, and effective prescription and use of psychotropic therapies for children, and on assisting States and Tribes in strengthening oversight and monitoring practices related to psychotropic medication use among children in foster care. These activities are responsive to recent legislation that requires greater oversight of psychotropic medication use for foster children, and they address long-standing criticisms that State and Federal efforts have failed to adequately regulate psychotropic use in this population.[41]

To help States with the development of the psychotropic medication oversight and monitoring components of their health care oversight and coordination plan, the Administration on Children, Youth and Families (ACYF) is providing multiple opportunities for information-sharing and technical assistance (TA) in advance of the submission of the APSR due June 30, 2012. The TA activities described here primarily focus on State title IV-B agencies, although many may be useful to Tribes, as well. Additional activities directed toward the specific needs of Tribes that administer title IV-B, subpart 1 programs are currently under development.

ACYF technical assistance efforts include:

- A three-part topical webinar series providing additional in-depth information on this topic was produced with assistance from Georgetown University and the American Institutes for Research through an inter-agency agreement with the Substance Abuse and Mental Health Services Administration (SAMHSA). Links to the recordings of these webinars are available on the Child Welfare Information Gateway.

[41] Camp, A.R. (2011). A mistreated epidemic: State and federal failure to adequately regulate psychotropic medications prescribed to children in foster care. *Temple Law Review*. *R*etrieved from http://ssrn.com/abstract=1567682.

- Additional information, resources, and tools pertaining to the use and oversight of psychotropic medications have been added to the Child Welfare Information Gateway, which will continue to be updated. This includes dissemination of guidelines developed by professional associations and information about exemplary practices in place in some States. One particularly useful document available on the Child Welfare Information Gateway is the Appendix from the 2010 study by Leslie, et. al (referred to above), which references numerous publications and web-based resources on this topic and also highlights useful and innovative tools developed by the States surveyed – many of which may be applicable to States as they refine their own oversight and monitoring procedures.

- Three peer-to-peer learning exchanges to allow information and resource sharing and opportunities to highlight exemplary practices from around the country. These events are designed to provide support to those leaders in child welfare, mental health and Medicaid who are working together to develop the protocols for the oversight and monitoring of psychotropic medications in the health care coordination and oversight component of the title IV-B plan, and will feature brief expert presentations on key considerations related to oversight and monitoring plan components, followed by an open information-sharing dialogue among participants with opportunities to consult with experts in the field.

In additional to this IM which defines the problem and provides resources for States to consider when determining how they will meet the new requirements of the title IV-B plan, CB has issued related Program Instructions ACYF-CB-PI-12-05 and ACYF-CB-PI-12-06that provides further guidance on required APSR content for States and Tribes, respectively.

Finally, after the 2012 APSR submission, ACYF, in collaboration with SAMHSA and the Center for Medicare & Medicaid Services (CMS), is convening a two-day meeting to bring together representatives from State child welfare, Medicaid, and mental health authorities from all fifty States, the District of Columbia, and Puerto Rico to work together to strengthen oversight and monitoring of psychotropic medications for children in foster care.

This meeting entitled, "Because Minds Matter: Collaborating to Strengthen Management of Psychotropic Medication Use for Children and Youth in Foster Care," will be held in August, 2012 to:

- Provide an opportunity for State leaders to enhance existing cross-system efforts to ensure appropriate use of psychotropic medications;
- Showcase collaborative projects and initiatives at State- and local-levels;
- Offer state-of-the-art information on cross-system approaches for improving mental health and well-being outcomes for children and their families;
- Allow participants to strategize to address the mental health and trauma-related needs of children in foster care with evidence-based and evidence-informed interventions; and
- Facilitate each State's development of action steps to improve upon and implement their existing health care oversight and coordination plans.

Additional ongoing activities will also enhance psychotropic medication oversight. CMS is responsible for administering Medicaid funding for health care services for all Medicaid-eligible

children, including children in foster care. CMS will continue to share information, establish quality measures, and improve continuity of eligibility and care. [42] They are also working with States to enhance their Drug Utilization Review programs, which allow States to monitor dispensing at the point-of-sale, the pharmacy counter, and to influence prescriber behavior. CMS also will encourage providers to adopt, implement, upgrade, and meaningfully use Electronic Health Records (EHRs) in order to access the Medicaid and Medicare EHR incentive payments. EHRs can improve the consistency and quality of health services for children, especially those whose residences change frequently. The development of quality health homes, standards for behavioral health, and behavioral health coverage for children and adults are among the practices that CMS will promote.

Promoting the increased use of evidence-based screening, assessment, and treatment: Other HHS actions will serve to expand the use of evidence-based and evidence-informed practices for the identification and treatment of social-emotional, behavioral, and mental health problems among children who have experienced maltreatment. There are effective treatments for the mental health disorders and trauma symptoms common among children in foster care. Any effort to ensure the appropriate use of psychotropic medications for these children must be accompanied by increased availability of evidence-based psychosocial treatments that meet the complex needs of children who have experienced maltreatment. Increased access to timely and effective screening, assessment, and non-pharmaceutical treatment will reduce the potential for over-reliance on psychotropic medication as a first-line treatment strategy, and increase the likelihood that children in foster care will exit to positive, permanent settings, with the skills and resources they need to be successful in life. Toward that end, HHS is actively disseminating existing information about effective pharmacological and behavioral practices for children in foster care through webinars and the Child Welfare Information Gateway. [43]

HHS is expanding the evidence base by funding research and demonstration projects that investigate both client-level interventions and system strategies to improve well-being outcomes for children and families. The Agency for Healthcare Research and Quality has contracted for an evidence review of interventions that address child exposure to familial trauma in the form of maltreatment or family violence. [44] Additionally, through its work with the National Child Traumatic Stress Network, SAMHSA continues its work to define best practices and to develop resources to meet the needs of trauma-exposed children and their families. Meanwhile, ACYF has organized its discretionary funding to promote the social and emotional well-being of children and youth who have experienced maltreatment. For example, in FY 2011, a cluster of five grantees received a total of $3.2 million to implement evidence-based, trauma-focused practices and to evaluate their impact on safety, permanency, and well-being outcomes.

Finally, a forthcoming IM on Promoting Social and Emotional Well-Being for Children and Youth Receiving Child Welfare Services will provide States, Territories and Tribes with more

[42] Retrieved from: http://www.childwelfare.gov/systemwide/mentalhealth/effectiveness/jointlettermeds.pdf

[43] The Child Welfare Information Gateway can be accessed through the following website: http://www.childwelfare.gov/. Child Welfare Information Gateway connects child welfare and other professionals to information and resources related to protecting children and strengthening families.

[44] Retrieved from: http://www.effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productid=846

information on the effects of childhood trauma and ways to promote social and emotional well-being.

Effective Date: Upon issuance.

Inquiries: Children's Bureau CB Regional Program Managers.

/s/

Bryan Samuels
Commissioner

Attachment A: CB Regional Office Program Managers

Regional Program Managers ATTACHMENT A

I	**Region I - Boston** Bob Cavanaugh bob.cavanaugh@acf.hhs.gov JFK Federal Building, Rm. 2000 Boston, MA 02203 (617) 565-1020 **States:** Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	VI	**Region VI - Dallas** Janis Brown janis.Brown@acf.hhs.gov 1301 Young Street, Suite 945 Dallas, TX 75202-5433 (214) 767-8466 **States:** Arkansas, Louisiana, New Mexico, Oklahoma, Texas
II	**Region II - New York City** Junius Scott junius.scott@acf.hhs.gov 26 Federal Plaza, Rm. 4114 New York, NY 10278 (212) 264-2890 **States and Territories:** New Jersey, New York, Puerto Rico, Virgin Islands	VII	**Region VII - Kansas City** Rosalyn Wilson rosalyn.wilson@acf.hhs.gov Federal Office Building Room 276 601 E 12th Street Kansas City, MO 64106 (816) 426-3981 **States:** Iowa, Kansas, Missouri, Nebraska
III	**Region III - Philadelphia** Lisa Pearson lisa.pearson@acf.hhs.gov 150 S. Independence Mall West - Suite 864 Philadelphia, PA 19106-3499 (215) 861-4000 **States:** Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia	VIII	**Region VIII - Denver** Marilyn Kennerson marilyn.kennerson@acf.hhs.gov Federal Office Building 1961 Stout Street - 9th Floor Denver, CO 80294-3538 (303) 844-3100 **States:** Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming
IV	**Region IV - Atlanta** Ruth Walker ruth.walker@acf.hhs.gov Atlanta Federal Center 61 Forsyth Street S.W. Suite 4M60 Atlanta, GA 30303 (404) 562-2900 **States:** Alabama, Mississippi, Florida, North Carolina, Georgia, South Carolina, Kentucky, Tennessee	IX	**Region IX - San Francisco** Douglas Southard douglas.southard@acf.hhs.gov 90 7th Street - 9th Floor San Francisco, CA 94103 (415) 437-8425 **States and Territories:** Arizona, California, Hawaii, Nevada, Outer Pacific—American Samoa Commonwealth of the Northern Marianas, Federated States of Micronesia (Chuuk, Pohnpei, Yap) Guam, Marshall Islands, Palau
V	**Region V - Chicago** Angela Green angela.green@acf.hhs.gov 233 N. Michigan Avenue Suite 400 Chicago, IL 60601 (312) 353-9672 **States:** Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin	X	**Region X - Seattle** Tina Minor tina.minor@acf.hhs.gov 2201 Sixth Avenue, Suite 300, MS-70 Seattle, WA 98121 (206) 615-3657 **States:** Alaska, Idaho, Oregon, Washington

Regional Program Managers ATTACHMENT A

I	**Region I - Boston** Bob Cavanaugh bob.cavanaugh@acf.hhs.gov JFK Federal Building, Rm. 2000 Boston, MA 02203 (617) 565-1020 **States:** Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	VI	**Region VI - Dallas** Janis Brown janis.Brown@acf.hhs.gov 1301 Young Street, Suite 945 Dallas, TX 75202-5433 (214) 767-8466 **States:** Arkansas, Louisiana, New Mexico, Oklahoma, Texas
II	**Region II - New York City** Junius Scott junius.scott@acf.hhs.gov 26 Federal Plaza, Rm. 4114 New York, NY 10278 (212) 264-2890 **States and Territories:** New Jersey, New York, Puerto Rico, Virgin Islands	VII	**Region VII - Kansas City** Rosalyn Wilson rosalyn.wilson@acf.hhs.gov Federal Office Building Room 276 601 E 12th Street Kansas City, MO 64106 (816) 426-3981 **States:** Iowa, Kansas, Missouri, Nebraska
III	**Region III - Philadelphia** Lisa Pearson lisa.pearson@acf.hhs.gov 150 S. Independence Mall West - Suite 864 Philadelphia, PA 19106-3499 (215) 861-4000 **States:** Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia	VIII	**Region VIII - Denver** Marilyn Kennerson marilyn.kennerson@acf.hhs.gov Federal Office Building 1961 Stout Street - 9th Floor Denver, CO 80294-3538 (303) 844-3100 **States:** Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming
IV	**Region IV - Atlanta** Ruth Walker ruth.walker@acf.hhs.gov Atlanta Federal Center 61 Forsyth Street S.W. Suite 4M60 Atlanta, GA 30303 (404) 562-2900 **States:** Alabama, Mississippi, Florida, North Carolina, Georgia, South Carolina, Kentucky, Tennessee	IX	**Region IX - San Francisco** Douglas Southard douglas.southard@acf.hhs.gov 90 7th Street - 9th Floor San Francisco, CA 94103 (415) 437-8425 **States and Territories:** Arizona, California, Hawaii, Nevada, Outer Pacific—American Samoa Commonwealth of the Northern Marianas, Federated States of Micronesia (Chuuk, Pohnpei, Yap) Guam, Marshall Islands, Palau
V	**Region V - Chicago** Angela Green angela.green@acf.hhs.gov 233 N. Michigan Avenue Suite 400 Chicago, IL 60601 (312) 353-9672 **States:** Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin	X	**Region X - Seattle** Tina Minor tina.minor@acf.hhs.gov 2201 Sixth Avenue, Suite 300, MS-70 Seattle, WA 98121 (206) 615-3657 **States:** Alaska, Idaho, Oregon, Washington