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Medicating TRAUMA

Improving Prescription Oversight of Children in Foster Care

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At the tender age of 7, Trevor suffered a profound tragedy that devastated his family and permanently altered the course of his life.[1] One spring afternoon, Trevor's mother left him home alone with six younger children, ranging in age from 4 months old to 5 years old. While she got drunk at a local bar, Trevor's 2-year-old half sister drowned in the bathtub. Trevor's parents were arrested, and Trevor and his brother were placed in Georgia's foster care system. Upon their release from jail, Trevor's parents reclaimed custody of Trevor's sibling, left the state, and abandoned Trevor forever.

Trevor's intake assessment at the time of his entry into foster care described him as a "pleasant, enjoyable, and active 7-year-old," who was protective and nurturing toward his brother. But trauma can derail normal development, and Trevor's trauma was extensive. Difficult memories of his sister's death and a series of disrupted attachments have led him to be admitted to state mental health facilities multiple times during his years in foster care. Trevor also acquired numerous mental and behavioral health diagnoses, for which he was prescribed medication. He received minimal traditional psychotherapy. At 14, Trevor was ingesting nineteen doses of seven different psychotropic medications daily to manage his emotions and behavior.

The adverse side effects of this heavy medication load affected both Trevor's physical and his psychosocial functioning. He had involuntary muscle movements and difficulty tracking conversation and interacting socially. Thus Trevor did not appeal to parents seeking to adopt a child, despite his strongly expressed desire for a family. His emotional and behavioral problems and the medications that were prescribed to manage them hindered his functioning and prevented him from being adopted. A comprehensive review of records revealed a troubling pattern of care: several diagnoses had not been revisited once made, multiple prescriptions targeting the same symptoms were being administered at the same time, new medications had been steadily added and dosages increased without adjusting the current medication regimen, and laboratory

[1] I have changed Trevor's name to protect his confidentiality; all factual references are made on the basis of case records in my files.

monitoring recommended for the medications was not well documented. When interviewed, Trevor could not describe what medications he was on or why he was taking them.

Cases such as Trevor's are all too common. Trevor fits the profile of a child who is most likely to be prescribed psychotropic medications: he is male and between 12 and 16 years old, he exhibits harmful behavior toward himself and others, and he is a child in foster care placed in a restrictive group-home setting.[2] Any roomful of children's attorneys would have a similar case. Children such as Trevor have complex needs, and our public health and foster care systems largely lack the resources and flexibility to meet those needs comprehensively. Psychotropic medications have become the expedient solution for responding to children's behavioral and emotional disturbances in this environment, and, until recently, practitioners and policymakers were largely without focused strategies to solve the problem of improper medication.

The dramatic increase in the use of psychotropic medications and the corresponding rapid expansion of state Medicaid budgets have created the perfect storm to drive state and national attention to health outcomes for Trevor and children in similar circumstances. The lack of specific evidence-based guidance on safe and appropriate use of these substances for children is fueling demand for closer supervision and monitoring of prescribing practices with the foster care population. Simply put, poor health care results are at a high cost to states. Here I present the trends in the psychotropic medication of children in foster care, describe the relationship between those trends and child welfare system characteristics, and offer strategies for practitioners to improve case outcomes and influence systemic oversight.

Trends in Psychotropic Medication

Research studies confirm what experience has already taught us: medicating children is becoming increasingly common. Psychotropic medication use among youths has increased two- to threefold over the last decade.[3] The problem is amplified for children in foster care. The Tufts Institute's recent analysis of the policies and practices of forty-seven states and the District of Columbia showed rates of psychotropic medication use for youths in foster care to range from 13 percent to 52 percent compared with 4 percent in the general youth population.[4] This comparison holds up when children in foster care are compared with non-foster-care children covered by Medicaid. The U.S. Government Accountability Office found that children in foster care in five selected states were prescribed psychotropic medications at rates 2.7 to 4.5 times higher than Medicaid-enrolled children not in foster care.[5] High rates of psychotropic medication use among children in foster care are a product of many interrelated forces, the most significant being the lack of clinical guidance on safety and efficacy and the unique treatment reality of the foster care system. The elevated rates of psychotropic medications in this population may also reflect increased levels of emotional and behavioral distress. The problem of improper psychotropic medication use is complex, and the strategies to combat it must be as sophisticated.

Lack of Clinical Guidance. Reports on trends in prescribing practices are alarming, but they do not reveal much about underlying clinical judgment or the appropriate role of medication in treatment. Many children have mental health problems requiring intervention,

[2]Ramesh Raghavan et al., *Psychotropic Medication Use in a National Probability Sample of Children in the Child Welfare System*, 15 Journal of Child and Adolescent Psychopharmacology 1, 97–106 (2005).

[3]Mark Olfson et al., *National Trends in the Use of Psychotropic Medications by Children*, 41 Journal of the American Academy of Child and Adolescent Psychiatry 5, 514, 516 (2010).

[4]Laurel K. Leslie et al., Tufts Clinical and Translational Science Institute, Multi-State Study on Psychotropic Medication Oversight in Foster Care (Sept. 2010), http://bit.ly/UcR3ms.

[5]U.S. Government Accountability Office, GAO-12-270T, HHS Guidance Could Help States Improve Oversight of Psychotropic Prescriptions (Dec. 1, 2011), http://1.usa.gov/RE8h7X.

which may include the use of medication as part of a comprehensive treatment approach. Because clinical research on the use of psychotropic medications in children is lagging behind prescribing trends, few of these substances have U.S. Federal Drug Administration indications for safe and appropriate use. In the absence of clinical guidance, physicians are left to adapt adult protocols for children, experiment with efficacy, and make assumptions about overall safety.[6] Variability characterizes the policies and practices governing the use of psychotropic medication in pediatric patients, particularly those in foster care.

One such variation is the increasing rates of polypharmacy, or the concurrent use of multiple medications from the same or different drug class, such as the seven medications Trevor ingested multiple times a day. According to experts, most psychotropic medication combinations lack adequate evidence of effectiveness and safety in children.[7] Children should rarely take multiple psychotropic medications at the same time. Rates of polypharmacy parallel the upward trends in the use of psychotropic medication. Polypharmacy has become an accepted practice in pediatric psychopharmacology, despite limited empirical support for any treatment advantages.[8] One study of Connecticut Medicaid-covered youths for whom psychotropic medications were prescribed found that 13.6 percent received more than one such medication from different drug classes concurrently.[9] Similarly, of Texas foster children who had been prescribed psychotropic medication, 41.3 percent received three or more different classes of these medications, 15.9 percent received four or more different classes, and 22.2 percent were given two or more medications from the same class at the same time.[10] Not surprisingly, high-risk practices involving excessive numbers of psychotropic medications have been the focus of recent congressional inquiry and litigation.[11]

Unique Problems in Mental Health Services. Studies show that children in foster care have disproportionate mental health needs that are often of greater complexity than the needs of the general youth population. Recognition of the role trauma plays in driving these needs is growing and beginning to influence the delivery of mental health services. Public mental health and child welfare systems are shifting toward "trauma-informed" treatment. The fragmentation of health care delivery in the foster care system, however, is a unique challenge in coordinating medical care and meeting the individualized mental health needs of each child in foster care.[12]

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[6]Julie M. Zito et al., *Off-Label Psychopharmacologic Prescribing for Children: History Supports Close Clinical Monitoring,* 2 Child and Adolescent Psychiatry and Mental Health (2008), http://bit.ly/REaOiq (off-label use of a drug is a common practice representing 50–75 percent of pediatric medication use, and use is based primarily on extrapolation of efficacy, dosing, administration, and side-effect profiles from adult studies).

[7]*Prescription Psychotropic Drug Use Among Children in Foster Care: Hearing Before the Subcomm. on Income Security and Family Support of the H. Comm. on Ways and Means*, 110th Congress 6–14 (May 8, 2008) (statement of Julie M. Zito, Professor of Pharmacy and Psychiatry, Pharmaceutical Health Services Research, University of Maryland, Baltimore), http://1.usa.gov/RBcMle.

[8]Daniel J. Safer et al., *Concomitant Psychotropic Medication for Youths*, 160 American Journal of Psychiatry 3, 438–39 (2003) (reviewing clinical research and practice literature relating to prevalence and patterns of concomitant psychotropic medication given to youths with emotional and behavioral disorders).

[9]Andres Martin et al., *Multiple Psychotropic Pharmacotherapy Among Child and Adolescent Enrollees in Connecticut Medicaid Managed Care*, 54 Psychiatric Services 1, 72 (2003).

[10]Julie M. Zito et al., *Psychotropic Medication Patterns Among Youth in Foster Care*, 121 Pediatrics 157, 159 (2007) (concluding that youths in foster care, as a group, have substantially more psychiatric disorders than their peers and that most disorders are behavioral in type).

[11]*The Financial and Societal Costs of Medicating America's Foster Children: Hearing Before the Subcomm. on Federal Financial Management, Government Information, Federal Services, and International Security of the S. Comm. on Homeland Security and Governmental Affairs*, 112th Cong. (Dec. 1, 2011), http://1.usa.gov/Vuv0HW; *Henry A. v. Willden*, No. 10-17680, 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 case of 11-year-old boy who was hospitalized and suffered near organ failure as result of adverse reaction to psychotropic medications), aff'd in part, rev'd in part, remanded, 678 F.3d 991 (9th Cir. 2012).

[12]U.S. Government Accountability Office, *supra* note 5.

Illness Severity and Prevalence. An extensive body of research confirms that children in foster care have more mental health needs than children in the general population.[13] Children in foster care are at extremely high risk of emotional and behavioral disturbances due to abuse or neglect, family disorder, disrupted attachments, and loss of support.[14] A foremost expert on trauma explains that the most serious mental health problems are "interpersonal in nature, intentional, prolonged, and repeated.... They include sexual abuse or incest, physical abuse, severe neglect, and serious emotional and psychological abuse."[15] Witnessing violence, repeated abandonment, and sudden losses can also be trauma-inducing.[16] These adverse events characterize the experience of every child in foster care. Thus children and adolescents in foster care use mental health services at higher rates than other Medicaid-eligible youths.[17] These findings suggest greater illness severity among this population, although other factors are at play.[18]

Diagnostic Challenges. Children with histories of maltreatment often have complex trauma-related mental health needs; that is, abused and neglected children may develop extreme coping strategies to manage the impact of traumatic stress, some appearing to be symptoms of mental and behavioral illnesses.[19] For example, traumatized children in foster care may display aggression, sleeplessness, inattentiveness, and difficulties adapting to new school settings and familial placements. Psychotropic medications are being used to manage emotional problems and disruptive behavior when nonpharmacological approaches may be more suitable to treating the underlying trauma.

Studies indicate that children in foster care are diagnosed more frequently with depressive disorders, anxiety disorders, attention deficit hyperactivity disorder, conduct disorder, bipolar disorder, and oppositional defiant disorder, at rates greater than children with disabilities and comparable Medicaid-eligible children.[20] The psychotropic medications used to treat these particular disorders are among those most commonly prescribed for children.[21] However, their use in clinical practice has far outpaced the available data on safety and efficacy.[22] One study of youths in Connecticut's Medicaid managed-care program found that the status of being in state custody

[13]See B.J. Burns, et al., *Mental Health Need and Access to Mental Health Services by Youths Involved with Child Welfare: A National Survey*, 43 Journal of the American Academy of Child and Adolescent Psychiatry 8, 960–70 (2004) (reporting approximately one-half of youths who enter child welfare system have some emotional or behavioral problem, but only 55 percent receive mental health services that align with national standards). See also Ramesh Raghavan et al., *A Preliminary Analysis of the Receipt of Mental Health Services Consistent with National Standards Among Children in the Child Welfare System,* 100 American Journal of Public Health 4, 742–49 (2010).

[14]See generally Mark D. Simms et al., *Health Care Needs of Children in the Foster Care System*, 106 Pediatrics 4 (Suppl.), 909–18 (2000). See also Zito et al., *supra* note 10.

[15]National Center for Trauma-Informed Care, Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services 2 (compiled by Ann Jennings, 2008), http://1.usa.gov/ZZ6rDo.

[16]*Id.*

[17]Susan dosReis et al., *Mental Health Services for Youths in Foster Care and Disabled Youths*, 91 American Journal of Public Health 7, 1094–1099 (2001).

[18]See Erik Parens & Josephine Johnston, *Understanding the Agreements and Controversies Surrounding Childhood Psychopharmacology*, 2 Child and Adolescent Psychiatry and Mental Health 1, 5 (2008) (discussing role of genetics, societal values, screening sensitivity, expediency and cost-effectiveness of medication, and limitations of diagnostic criteria in identifying and treating mental illness).

[19]National Center for Trauma-Informed Care, *supra* note 15.

[20]Jeffrey S. Harman et al., *Mental Health Care Utilization and Expenditures by Children in Foster Care*, 154 Archives of Pediatric and Adolescent Medicine 11, 1114–17 (2000).

[21]Mark A. Riddle et al., *Pediatric Psychopharmacology,* 42 Journal of Child Psychology and Psychiatry 1, 73–90 (2001).

[22]*Id*.

was the single strongest predictor of psychotropic drug use, indicating the prevalence of psychotropic drug use in the foster care system.[23]

These diagnoses are based on behavioral issues, mood shifts, or difficulty sustaining attention, which cannot fully be understood outside the context of a child's trauma. A child such as Trevor may receive multiple diagnoses that change with time, placement setting, and medical provider. When a child enters foster care, the child becomes categorically eligible for state Medicaid benefits. At this stage and every time a child changes foster care placement, the child is likely to change medical providers. Placement instability has been found to be associated with mental health service use.[24] National estimates indicate that two-thirds of children in foster care for more than a year have three or more placements.[25] Furthermore, a child's medical records often do not follow the child as the child's placements change, and so a treating physician does not have the luxury of medical history to inform the physician's clinical impressions. For these reasons, revisiting a diagnosis, particularly when new symptom patterns emerge, is critical. Clinical practices that ensure timely assessment and reassessment and that facilitate information sharing are opportunities to disrupt patterns of overdiagnosis and improper medication. Physicians must be supported through quality child welfare casework to obtain a clear diagnostic picture and consider psychosocial interventions as an alternative to, or in combination with, medication therapies.

Advocacy to Improve Outcomes

The state has a duty to ensure that children in foster care receive adequate health care to meet their individual needs, no matter how complex those needs may be. Ironically the inherent instability of foster care undermines the child welfare system's efforts to fulfill this duty and contributes to the overuse of psychotropic medications. As the American Academy of Child and Adolescent Psychiatry recognizes, "unlike 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."[26] Rather, the sharing of legal and caretaking duties among foster parents, group home staff, treatment providers, attorneys, judges, court-appointed special advocates, the assigned caseworker, and agency administrators may diffuse responsibility and can exacerbate the fragmentation of medical care.

Too often, foster care involves multiple and frequent placement changes, overreliance on emergency room care, lack of proper psychiatric assessment and reassessment, and gaps in the system of care. Inaccurate record keeping and inconsistent sharing of medical information are a further challenge to improvement efforts. Thus longitudinal coordination of health care for a child is difficult. Despite such challenges, child welfare systems and legal practitioners must devise strategies to ensure that children receive appropriate health care.

Federal Child Welfare Mandates. Legal practitioners can leverage the direction taken by federal law. In 1997 the Adoption and Safe Families Act established that the health and safety of children in foster care are the paramount concern.[27] To that end, federal law requires that the individualized case plan for each child in foster care have the health records of the child, including names and addresses of

[23]Andres Martin et al., *Multiple Psychotropic Pharmacotherapy Among Child and Adolescent Enrollees in Connecticut Medicaid Managed Care*, 54 Psychiatric Services 1, 72, 75 (2003).

[24]David M. Rubin et al., *Placement Stability and Mental Health Costs for Children in Foster Care*, 113 Pediatrics 5, 1336 (2004), http://bit.ly/PUh3BP.

[25]Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services, Child Welfare Outcomes 2002–2005: Report to Congress (May 22, 2008), http://1.usa.gov/VQFr4f.

[26]American Academy of Child and Adolescent Psychiatry, AACAP Position Statement on Oversight of Psychotropic Medication Use for Children in State Custody: A Best Principles Guideline (2005), http://bit.ly/SOASKe.

[27]Adoption and Safe Families Act, 42 U.S.C. § 671(a)(15)(A) (2011).

providers, a record of immunizations, any known medical problems, medications, and any other relevant health information.[28] 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.[29] Legal practitioners can ensure that this valuable medical information is systematically collected, recorded, and shared as required. An electronic health record may be a strategy worth considering at an individual case level and as a systemic practice improvement.

Additional tools for legal practitioners are available as a result of recently enacted federal laws that, for the first time, call upon states to pay specific attention to the administration of psychotropic medications to children in foster care. The Fostering Connections to Success and Increasing Adoptions Act of 2008 requires state child welfare agencies to develop a comprehensive health care oversight and coordination plan which must provide oversight of prescription drugs generally.[30] The agency is encouraged to pay particular attention to the oversight of psychotropic medications in the portion of its plan that attends to the mental health needs of children in foster care.[31] The Child and Family Services Improvement and Innovation Act builds on this health care plan requirement further by specifying that child welfare agencies must develop protocols for the appropriate use and monitoring of psychotropic medications.[32] The Act also requires each state's plan for child welfare services to include a coordinated strategy outlining how a traumatized child's needs are monitored and treated.[33]

The purpose of these requirements is to ensure that children in foster care benefit from a highly coordinated, integrated, and sustainable system of health care. Legal practitioners should obtain the state's health care plan for children in foster care and advocate compliance with it in individual cases.

Youth Engagement in Medical Decisions. Advocates should facilitate an active role for children in their treatment. Research supports the capacity of youths to understand dosing information and indicated uses for the medications prescribed to them.[34] States vary in their procedures for giving consent to 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 a court order.[35] Some states have designated officials or offices to give consent to psychotropic medications.[36] These practices are supported by child welfare agency policies that define the scope of the agency's legal duty to provide "ordinary" or "routine" medical care for children in state custody without further specification as to what health

[28] *Id.* § 675(1)(C).

[29] *Id.* § 675(5)(D)(2012).

[30] Fostering Connections to Success and Increasing Adoptions Act of 2008, Pub. L. No. 110-351, 122 Stat. 3949 (2008), amending, inter alia, 42 U.S.C. § 673.

[31] *Id.*

[32] *Id.*, Pub. L. No. 112-34, 125 Stat. 369 (2011) (codified in scattered sections of 42 U.S.C.).

[33] Child and Family Services Improvement and Innovation Act, 42 U.S.C. § 622(b)(15)(A)(ii) (2012).

[34] See Louis A. Weithorn & Susan B. Campbell, *The Competency of Children and Adolescents to Make Informed Treatment Decisions*, 53 Child Development 1589, 1595 (1982) (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 when responding to medical and psychological treatment hypotheticals); Thomas Grisso & Linda Vierling, *Minors' Consent to Treatment: A Developmental Perspective*, 9 Professional Psychology 412, 417–18 (1978) (by age 15 children possess psychological abilities important to decision making and are no less competent than adults to give consent).

[35] Michael W. Naylor et al., *Psychotropic Medication Management for Youth in State Care: Consent, Oversight, and Policy Considerations*, 86 Child Welfare 5, 175–92 (2007).

[36] *Id.* (reporting on Illinois, where Department of Guardian and Advocacy gives consent to medical care; Connecticut, where designated program supervisors give consent; and Tennessee, where regional health nurses fulfill consent responsibilities).

care matters are considered to be routine. A few states specifically include or exclude psychotropic medications in their agency policies or as a matter of law.[37]

Many states recognize limitations on children's legal capacity to participate in medical decision making; this means that children cannot give informed consent, or withhold consent, to their own treatment. Legal practitioners may want to advocate children's role as assenters to the recommended medical treatment. 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.

The benefits of seeking children's assent to their treatment can be significant. Patient adherence to prescribed drug regimens is critical to ensuring treatment safety and efficacy. Nonadherence can pose risks, such as reduced efficacy, recurrence of symptoms, and withdrawal. Thus children's complete understanding of their diagnoses and acceptance of their treatment becomes vital. Typically giving informed consent promotes the necessary discussion of questions and concerns in an ongoing and dynamic fashion between the patient and the physician. That same way should be undertaken to obtain children's assent to their treatment.

To facilitate consent and assent, the American Academy of Child and Adolescent Psychiatrists recommends obtaining simply written psychoeducational materials and medication information to help children, their parents, and agency professionals understand medications and consent.[38] Legal practitioners, child welfare professionals, judges, and caregivers should also receive training on medication issues to enable them to be effective advocates for children in their custody.[39]

Improvements in Clinical Practice. To influence clinical practice, American Academy of Child and Adolescent Psychiatrists best-practice principles promote the establishment of guidelines for the use of psychotropic medications for children in state custody.[40] Many states have adopted prior authorization programs, adjusted drug formularies, or developed other use-management strategies. A variety of practice guidelines, sometimes called "medication utilization parameters," have been developed to inform prescribing practices. Common among these guidelines are provisions supporting comprehensive and coordinated screening, assessment, and treatment to identify children's mental health and trauma-related needs; shared decision making incorporating standards for informed consent and assent; medication monitoring at both the individual and agency level; availability of expert consultation for child welfare staff; and protocols for sharing health information among the treating physician, child welfare staff, the child, and the child's parents or caregivers. Legal practitioners should be aware of any guidelines in their state and what kind of response is generated for "red flag" cases in which outlier practices are identified.

Final Thoughts

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. Reports consistently confirm that children in foster care are prescribed these powerful

[37]See, e.g., Okla. Stat. tit. 10A, § 1-3-102(A)(1) (2012) (defining "routine and ordinary medical care and treatment" specifically to include provision of psychotropic medication); but see Fla. Stat. § 985.03(40) (2012) (defining "ordinary medical care" to exclude provision of psychotropic medications); see also Cal. Welf. & Inst. Code § 369.5(a) (2012) (vesting authority to make orders regarding administration of psychotropic medications to foster children with court).

[38]American Academy of Child and Adolescent Psychiatry, *supra* note 26.

[39]*Id*.

[40]*Id*.

substances at rates far greater than they are prescribed to children in the general population. Polypharmacy is also more common among children in foster care. These trends raise concerns because the safety and efficacy of these medications are not well established, particularly in terms of short- and long-term impact on a child's developing body and brain.

Among factors in these patterns are illness severity within the foster care population, insufficient oversight and monitoring of psychotropic medication use, gaps in coordination of health care, provider shortages, and lack of access to effective therapeutic alternatives to medications. As a result, states are too often achieving poor outcomes for vulnerable children at a high cost to state Medicaid programs. The call for increased oversight is timely. Designing a systemic approach to the management of medications in the high-risk foster care population, however, challenges policy, practice, and agency processes. A systemic solution requires intensive coordination among multiple agencies, expanded service capacity, knowledgeable advocates, and engaged families and children.

These features, even on a small scale, can brighten the outlook for children such as Trevor. As a result of an innovative partnership between Georgia's child welfare agency and its court system, Trevor is getting another chance. He has slowly been weaned from most of his medications under close medical supervision and is making progress toward normalization. His functioning restored, Trevor has greater personal and interpersonal successes, gaining him freedom and privileges in his group home. Intensive efforts to find family led to paternal grandparents, with whom Trevor has reconnected. He remains hopeful about his future, but the road ahead is still long, and thousands more children need help.

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