

**The Use of Psychotropic Medications
For Children and Youth
In the Texas Foster Care System**

*Report of the Texas Department of Family and Protective Services
Advisory Committee on Psychotropic Medications
September 2004*

I. INTRODUCTION

The use of psychotropic medications by children is an issue confronting parents and medical professionals across the United States. The therapeutic benefits that these medications have for many children must be balanced against the potential side effects for children receiving these drugs. The use of psychotropic medications by children in foster care also involves other stakeholders such as foster parents, the judicial system and child protective services staff. The Health and Human Services Commission (HHSC) and the Texas Department of Family and Protective Services (DFPS) are committed to ensuring that the foster children of Texas receive the very best care, both medical and non-medical, possible and that caseworkers and caregivers responsible for the care of foster children have the knowledge and skill to make informed decisions about their care.

Advisory Committee on Psychotropic Medications Appointed

The DFPS Advisory Committee on Psychotropic Medications was established by HHSC and DFPS in March 2004. This committee is made up of medical professionals, child and family advocates, foster parents, providers, foster care youth and human services professionals. For a complete list of committee members along with a description of how the committee completed its work, please refer to Appendix A.

Committee Charge

The committee was given the responsibility to research the issues related to the use of psychotropic medications by foster children and to submit a final report to HHSC and DFPS by September 1, 2004. The committee was asked to address the following issues in their final report:

- Define which medications are considered to be a psychotropic medication;
- Develop a list of psychotropic medications approved for use by foster children;
- Establish protocols and limits on the use of these medications; and
- Determine the best method to monitor the use of these medications by foster children.

Guiding Principles

The committee believes that it is important that DFPS establish and maintain a process that promotes a model of best practice in regards to the use of psychotropic medications for children and youth in the care of DFPS. Although a range of opinion exists among stakeholders regarding what constitutes best practice in regard to the use of psychotropic medication, the committee agreed on the following basic principles:

1. DFPS as managing conservator is responsible for making decisions related to the care and treatment of each child placed in its custody by the courts. This decision-making authority includes the use and management of psychotropic medication; and may be exercised directly by DFPS staff or through the delegation of authority to caregivers when appropriate. DFPS is responsible for keeping the courts informed about the care and treatment of children placed in its custody and following court-ordered instructions related to the care of these children.
2. The use of psychotropic medication is one treatment tool, which is used in conjunction with other treatment interventions to serve as a part of the child's total treatment plan. When used appropriately as a part of that treatment plan, psychotropic medications can improve the child's health and well being, including enabling the child to grow and develop more normally in attention span, emotional maturation, cognition, judgment and social skills.
3. Children should have a baseline assessment by a qualified professional prior to initiating the use of psychotropic medication. The use of psychotropic medication should be based on the assessment and supported by a treatment plan and must be consistent with the child's diagnosis/condition.
4. Children should have an active role in decisions related to management of their care, including the use of psychotropic medications. Children should receive information regarding the use of medication, purpose, side effects etc. appropriate to their age and developmental level.
5. When possible and appropriate, the child's family should have input in decisions related to the child's treatment including the use of psychotropic medication.
6. Foster parents and residential caregivers should be active participants in decisions and discussions around the use of psychotropic medication.

7. Providers of residential and foster care should clearly delineate their policies regarding the use of psychotropic and emergency medication in their treatment program, including practices related to the use and integration of psychotropic medication with other treatment methods.
8. DFPS policy and practice should include ways for foster children, parents, caregivers, caseworkers and other advocates involved with the child to express their views about what is best for the child in the area of psychotropic medication.

II. DEFINITION OF PSYCHOTROPIC MEDICATION

A psychotropic medication is any medication that acts primarily on the central nervous system and that is used primarily or adjunctively in the treatment of mental or neurological disorders.

III. PSYCHOTROPIC MEDICATIONS APPROVED FOR USE

The committee discussed the practice of prescribing medications to children that have not been approved by the Food and Drug Administration (FDA) for use in children. While the majority of medications employed in child psychiatry have not been studied extensively by the pharmaceutical industry their use can be beneficial. Physicians use information regarding research and clinical trials when making decisions regarding these medications. Medication used without FDA approval is not necessarily dangerous to a child; it means only that the drug has not been studied for use in children or the drug in question has not received FDA approval. The committee determined that the list of psychotropic medications approved for use by children and youth in foster care should be the same as those medications available for other Medicaid eligible children on a non-discriminatory basis. The list of psychotropic medications approved for use by foster children is based upon the Medicaid Preferred Drug List developed by HHSC. The current list of approved medications can be found in Appendix B. Please note that HHSC updates this list on a regular basis.

IV. RECOMMENDATIONS FOR PROTOCOLS AND MONITORING SYSTEMS

A. Establish an effective consultation and monitoring system for the use of psychotropic medications by foster children.

Background:

Children in the Child Protective Service (CPS) system placed in foster care face special challenges in the area of medical and psychiatric treatment. The psychiatric needs of children in foster care can be quite complex, and treating clinicians may have varying degrees of experience with this population of children and limited access to consultation with experts. When children move within the system, their complete medical history is not always accessible to the next physician. Also, foster children are treated by a wide range of physicians including family practice physicians, pediatricians, clinical staff and psychiatrists; and foster children who move within the system may be treated by multiple physicians with varied expertise and a range of clinical skills. Foster children in rural areas may have limited access to specialists.

Concerns exist regarding the inappropriate use of psychotropic medication and inadequate monitoring of prescribed medications. There is also a lack of data available regarding physician prescribing practices and child outcomes. Children in foster care may be subject to widely varied standards of care. There is currently no way to monitor the quality of care and no system for resolving concerns associated with the use of psychotropic medication for children. Also there is no method for “second opinions” to be easily obtained by DFPS staff when they have concerns or questions.

Goal:

Ensure that children in foster care receive consistent treatment, in keeping with currently accepted medical practice; and to provide easy access to expert clinical consultation services for DFPS staff, individual clinicians, and providers of residential and foster care.

Strategy:

Establish an effective statewide clinical consultation and monitoring system that is comprised of expert clinicians. Develop a systematic methodology that would address monitoring according to an accepted clinical standard of practice for “Red Flag” child cases. Such a system would recognize that appropriate dosages and numbers of medications may vary greatly and are based on a combination of factors (types and number of diagnoses, age, weight, physical condition of child, etc.). Therefore, not typically a single issue, but a range of factors should be considered to trigger a “Red Flag” protocol. Such a system also would also be supportive to enhancing child outcomes through consultation for the purpose of education and clarification.

The committee recommends instituting a Clinical Advisory Council (CAC) on the state level and Clinical Review Teams (CRT) in each region of the state. The following strategies are suggested to establish this clinical consultation and monitoring infrastructure:

1. Establish a statewide Clinical Advisory Council for quality monitoring related to the use of psychotropic medications.

- Composition should include a minimum of:
 - Two board-certified child psychiatrists (preferably more), one of whom should serve as the chairperson;
 - Representative(s) from DFPS,
 - An experienced quality specialist,
 - Member(s) who can assist with statistics, data interpretation, and information technology, and
 - Consumer representative(s)
- Members should be appointed by HHSC and DFPS executives.
- Initial tasks include:
 - Establishment/selection of clinical guidelines and protocols that can be appropriately and constructively applied to DFPS consumers. See Appendix B for a list of resources currently available.
 - Identification/selection of “Red Flag” indicators that can be applied electronically to the databases of DFPS cases in order to identify suspected problems in medication use.
 - Identification of competency requirements for the staff involved with care giving and case managing the child’s care in order to meet the newly established clinical guidelines and protocols.

- Identification of data to be collected statewide for monitoring clinical activities and child outcomes related to psychotropic medications.
- Recruitment of regional Clinical Review Teams of similar membership elements to the statewide committee with the possible addition of a family or behavioral therapist. Ideally, these Clinical Review Teams would be associated with university health sciences centers so that access to the various disciplines and to electronic teleconferencing would be more readily available.
- Annual tasks include:
 - Review of guidelines and protocols for updates or revisions. (In the event of noteworthy changes in prevailing practices, revisions will be considered as needed.)
 - Review of statewide aggregate data on medication usage patterns.
 - Review of system changes that may affect medication use or its monitoring.
 - Review of the operation of regional Clinical Review Teams to make adjustments and/or recommendations.
- Quarterly tasks include:
 - Review of regional data using “Red Flag” indicators and other statistics.
 - Referral of selected cases for detailed review by regional Clinical Review Team. (It is unlikely that all of the “Red Flag” cases would be referred.)
 - Review difficult cases referred up from regional Clinical Review Team.
 - Adjustment of “Red Flag” criteria as necessary.

2. Establish Clinical Review Teams in each DFPS region.

- Composition as described above.
- Quarterly meetings should include:
 - Recruitment and retention of members.
 - Cultivation of attendance and participation.
 - Detailed review of cases (possibly using teleconferencing):
 - Referred via the “Red Flag” process at the state level and
 - Referred locally or regionally because of specific problems.

- Minimum of one-year follow-up of cases after their reviews to evaluate changes in treatment and in response to treatment.
- Identification of cases of especially high complexity for referral to the statewide quality committee.
- Identification of system problems and recommendations for changes.
- Creation and maintenance of a log of activities and recommendations.

B. Improve the training system to be competency-based with expanded training topics and participants.

Background:

The current system is geared toward delivering training in the area of psychotropic medications; but does not require that participants demonstrate competency as a result of training. Current requirements related to medication training are not comprehensive in covering issues related to psychotropic medication and their effects.

Goal:

Improve the scope of training and education regarding the use of psychotropic medications and verify competencies in these areas.

Strategy One: Establish a Competency Focused Training System

Competency-based training will help ensure consistency across placement settings and will ensure a higher level of skills, knowledge and capability in caring for children receiving psychotropic medications. A “competency focused” educational process requires proof of a trainee’s knowledge, skills and capability related to the necessary care giving or case managing activities that revolve around the child. Competency focused education also puts a greater burden on those providing education to ensure care for the child is safe and effective in the area of psychotropic medication. Recommended features to ensure a more competency-based focus include:

- Provide for a system to train and prove initial and ongoing competency.
- Require post-test training.
- Require demonstration of ability following training for any skill-based topic.

- Require the residential childcare agency/program responsible for the child's care to have procedures and policies to deal with caregivers who do not demonstrate competency i.e. remedial training, supervised practice etc.

Strategy Two: Expand Training Topics

The committee recommends that all caregivers and case managers of foster children who receive psychotropic medications participate in ongoing competency focused training in the area of psychotropic medication. Training should include the following topical areas:

- General information related to psychotropic medication.
- Training on specific psychotropic medications.
- Training on the procedures for communicating and addressing concerns or issues related to the child's psychiatric treatment.
- Training in advocacy, and child and family rights in this area.

The committee also recommends that psychotropic medication training could include computer-based training modules, teleconferencing, video-conferencing and other teaching formats based on adult learning styles including matching seasoned foster/adoptive parents as mentors for new foster/adoptive parents. The committee further recommends that the degree of knowledge and competency in any specific training area should be matched to the roles and responsibilities of the training participants.

Training on General Information

Training on general information related to psychotropic medication and medication management should include the following suggested topics:

- Specific psychological, behavioral, physical, developmental and psychiatric disorders for which psychotropic medications are appropriately prescribed.
- How the use of medication is supported by other psychosocial interventions and treatment techniques.
- The effects of using medication in children. Information regarding how age, developmental considerations, gender, ethnicity and history of

sexual or physical abuse may affect the manner in which a child has desirable or undesirable effects from psychotropic medication.

- What to do in case of medication refusal by a child.
- Training on the use of emergency psychotropic medication (if allowed by the residential childcare agency/program).

Training on Specific Psychotropic Medications

Training specific to psychotropic medication issues should include the following suggested topics:

- Medication that is identified as within the “psychotropic medication” categories.
- Each medication’s expected benefits as used alone and/or in combination with other medication or treatment interventions.
- Each medication’s delineated adverse reactions and common side effects.
- Undesirable child behaviors, which should be observable (i.e., too low or too high activity tolerance, too sleepy) that could be related to these medications.
- Desirable child developmental effect, which should be observable (i.e., increased attention span, increased progression in social, emotional, cognitive or physical growth) that could be related to these medications.
- Undesirable child developmental effects, which should be observable (i.e., decreased attention span, decreased progression in social, emotional, cognitive or physical growth) that could be related to these medications.
- How the medication might interact with other medication, including multiple psychotropic medications.

Training on Notification of Problems

Training on when and how to notify responsible clinicians, DFPS supervisors, residential and foster care clinical and management staff etc. of undesirable effects, complications or outcomes related to psychotropic medication, which should include:

- Specific instructions on how to document and report any adverse behaviors, or suspected side effects.
- Specific actions to notify previously identified responsible clinical and/or supervisory persons and organizations and the timeline for those actions.
- Specific actions to follow up the “notification” and the timeline for follow up actions.
- Procedures for accessing the Clinical Review Team for additional consultation, second opinion etc.

Training on Child Advocacy

Training related to advocacy for children on psychotropic medications should include:

- Child, managing conservator, and family rights to be notified of treatment interventions including the use of psychotropic medication as part of a treatment plan.
- Informed Consent (what does it entail, who has the right to give informed consent, and what to do if consent is revoked).
- Advocating for children in the area of medication.
- For foster parents and residential caregivers: how to prepare for medication monitoring by a physician, what documentation to have ready, what to take, what questions to ask etc.

Strategy Three: Expand the Requirements for Who Must be Trained

- DFPS should incorporate recommended training into staff development for those responsible for making case management decisions.
- Current requirements for residential and foster care provider training include training caregivers in the identification of the psychotropic medication, basic pharmacology; techniques and methods of administering medications; and related policies and procedures. A physician, pharmacist or Registered Nurse must provide this training. Expanded recommended training requirements should be added through the appropriate means.

C. Address Informed Consent.

Background:

While Texas has enacted laws dealing with informed consent for the administration of psychotropic medications for patients receiving mental health services in a mental health facility, there are no such statutory guidelines dealing with the administration of psychotropic medications to foster children. Several states have enacted rules or statutes requiring informed consent by the child and the child's parent or guardian before the administration of psychotropic drugs to a child in foster care.

Goal:

Develop clear provisions regarding informed consent required for the administration of psychotropic medications to foster children.

Strategy:

DFPS should form a committee to review current consent requirements and to develop recommendations on how informed consent requirements could be applied to the administration of psychotropic medications to foster children. Informed consent should be presented in terminology clearly understood by the caregiver, parent and child. In situations where written consent cannot be immediately obtained, and withholding medication would create undue risk, verbal consent will suffice until written consent is received. Information provided to give informed consent should contain, at a minimum, the following:

- The child's condition or symptoms for which the medication is being prescribed
- The intended outcomes, expected benefits of treatment and potential side effects
- Alternatives to the proposed treatment
- The likelihood of success
- The right to withhold consent or withdraw consent
- The likely outcome and risks of not treating with medications
- An acknowledgement that there may be unknown risks with medication use

V. ADDITIONAL RECOMMENDATIONS

1. DFPS should seek funding to conduct or commission a study to examine the current trends in prescribing psychotropic medications to children and youth placed in residential and foster care by DFPS. This study should include analysis of the type of medications that foster children receive and the concomitant diagnoses; and an analysis of the specialty of prescribing physicians. This study should be organized by age, ethnicity, gender and specific psychotropic medications prescribed; and should include a comparison to an age-matched group of Medicaid non-foster children in Texas.
2. Consider the use of a Medical Passport for children in the foster care system in order to improve continuity of medical care.
3. We recommend that DFPS initiate a public/private work group to design and implement an improved and expanded competency-based training program that is correlated with the previously described clinical monitoring and consultation system. This work group should include foster parents experienced in the administration of psychotropic medications and adults formerly cared for in the Texas foster care system.

Final Report Submitted

The DFPS Committee on Psychotropic Medications is pleased to submit its final report to Commissioner Thomas Chapmond. The committee believes that the implementation of the recommendations included in this report will benefit the foster children of Texas. In addition to the recommendations, several committee members have added individual comments to this report. These comments are found in Appendix C.

Appendix A

The Committee

DFPS invited thirteen individuals to participate in the first committee meeting held in Austin on April 22, 2004. During the first meeting the committee determined additional stakeholders should be added to the committee. The committee recommended that individuals representing biological parents, the judiciary, former foster children, clinical psychology and foster parents be added to the committee. Nine additional individuals were added to the committee between the April 22nd meeting and the second committee meeting on May 26, 2004. Members of the committee including titles/affiliations follow:

- Richard Adams, M.D., Texas Scottish Rite Hospital for Children, Associate Professor of Pediatrics at University of Texas, Southwestern Medical Center
- Roy Block, President, Texas Foster Family Association
- Caroline Bogues, Youth Specialist, DFPS
- Matt Brams, M.D., Medical Director, DePelchin Children's Center
- Stephany Bryan, Parent Collaboration Coalition
- Joseph H. Burkett, M.D., Medical Director MHMR of Tarrant County
- Sally Carmen, RN, MSN, CPNP, Children's Medical Center and WTAMU School of Nursing
- Sylvia A. Chavez, Associate Judge, Child Protection Court of the Permian Basin
- M. Lynn Crismon, Pharm. D., Professor of Psychiatric Pharmacy, University of Texas at Austin
- Audrey Deckinga, CPS Division Administrator, DFPS
- Bonnie Finley, LMSW, Vice President, The Bair Foundation
- Marcia Garcia, M.Ed., Program Director Uniting Parents; Coalition of Health Services Inc.
- Bob Hartman, Exec. V.P./ Chief Operating Officer, DePelchin Children's Center
- Nancy Holman, Executive Director, Texas Alliance of Child and Family Services
- Alex Kudisch, M.D.
- Richard LaVallo, Advocacy, Inc.
- Beverly Levy, Executive Director, Dallas CASA
- Ed Liebgott, Executive Director, Youth For Tomorrow
- Molly A. Lopez, PhD., Interim Director of Research and Academic Collaboration, MHMR
- Cassie Mitchell, Foster Parent
- Gibby Serna, Youth Specialist, DFPS
- Gail Woodward, Best Practices Initiatives Program Specialist, DFPS

Other Participants

Tina Janek served as the facilitator for the committee. Ms. Janek's participation was made possible by generosity of the Casey Family Program in Austin. DFPS assigned Moe Dozier and Scott Engelke from the Advancing Residential Childcare Project to support the work of the committee. The following people served as resources to the committee: Audrey Puryear, Texas Alliance of Child and Family Services; Sasha Rasco, DFPS; Conni Barker, J.D., Director of Government Affairs, DePelchin Children's Center; and Janice Lehman, Youth for Tomorrow.

Committee Process

In its first meeting the committee decided that all committee meetings would be open to the public and decisions would be made by consensus. The committee also decided that committee members would be able to include dissenting views in the final committee report. The committee determined the best process for completing the work was to utilize subcommittees to develop recommendations for consideration by the full committee. Sally Carmen was selected as the chairperson for the Protocols Subcommittee and Dr. Matt Brams was selected as the Chairperson for the Definitions Subcommittee. Committee members were encouraged to participate on one or both of these subcommittees. Subcommittee chairpersons were empowered to utilize the input from other stakeholders. Those individuals serving as resource to the subcommittee are identified above. During the July 13, 2004 committee meeting it was decided that a Writing Subcommittee would be used to draft the report and present the draft to the full committee. The Writing Subcommittee was composed of Matt Brams, Sally Carmen, Audrey Deckinga, Moe Dozier, Maria Garcia, Bob Hartman and Nancy Holman. The committee made changes to the draft during its meeting on August 12, 2004. Changes to the report were incorporated and the final report was submitted to the committee for review and approval. One committee member did not approve the final report. The comments of this committee member and other committee members can be found in Appendix C.

Disclosure of Financial Interests

All committee members along with DFPS staff, Ms. Janek and any resource person used by one of the subcommittees were asked to disclose any significant financial interest in the work of the committee. Financial disclosure statements were obtained from all participants in the work of the committee. Attached to this report is a copy of the disclosure statement used by the committee. Two committee members noted some financial interest. Completed disclosure statements on each participant are available for inspection by contacting Scott Engelke by e-mail (ARC@dfps.state.tx.us) or by telephone at 512-438-4840.

Appendix B

Resource

Medicaid Preferred Drug List

Please use this link to access the Medicaid Preferred Drug List:

<http://www.hpsc.state.tx.us/HCF/vdp/PT/TXMPDL.pdf>

Please note that the Medicaid Preferred Drug List is updated periodically and includes many prescribed medications other than psychotropic medications. Also please note that by use of the Prior Authorization Program, see below, physicians may prescribe both “preferred agents” and “non-preferred agents”; therefore both may be appropriate for use by foster children and youth.

Overview information regarding the Medicaid Preferred Drug List and Prior Authorization Program is available on the Texas Pharmaceutical and Therapeutics Committee website at: <http://www.hpsc.state.tx.us/HCF/vdp/PT/PT.html>

Use this link to access how the Prior Authorization process works:

http://www.hpsc.state.tx.us/HCF/vdp/PT/PA_Program.html

The following is an excerpt from the Medicaid Preferred Drug List that displays only psychotropic medications. This excerpt is included for convenience. Again, please note that the Medicaid Preferred Drug List is updated periodically.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS PA Not Required	NON-PREFERRED AGENTS PA Is Required	PA CRITERIA
ANTIDEPRESSANTS, OTHER (non-SSRI) (Oral) Effective 1/04 PA Implementation 3/29/04	bupropion EFFEXOR XR (venlafaxine) REMERON SOLTABS (mirtazapine) trazodone WELLBUTRIN XL (bupropion)	DESYREL (trazodone) EFFEXOR (venlafaxine) mirtazapine nefazodone REMERON Tablets (mirtazapine) SERZONE (nefazodone) WELLBUTRIN (bupropion) WELLBUTRIN SR (bupropion)	<ul style="list-style-type: none"> • Treatment failure with preferred product. • Contraindication to preferred product. • Allergic reaction to preferred product. • Patients on non-preferred therapy will be allowed to continue on that therapy.
ANTIDEPRESSANTS, SSRIs Effective 1/04 PA Implementation 3/29/04	fluoxetine LEXAPRO (escitalopram) PAXIL CR (paroxetine) PEXEVA (paroxetine) ZOLOFT (sertraline)	CELEXA (citalopram) fluvoxamine paroxetine PAXIL (paroxetine) PROZAC (fluoxetine) RAPIFLUX (fluoxetine) SARAFEM (fluoxetine)	<ul style="list-style-type: none"> • Treatment failure with preferred product. • Contraindication to preferred product. • Allergic reaction to preferred product. • Patients on non-preferred therapy will be permitted to continue on that therapy.
ANTIPSYCHOTICS, ATYPICAL (Oral) Effective 1/04 PA Implementation 3/29/04 *Symbyax PA Implementation 6/19/04	ATYPICAL ANTIPSYCHOTICS		<ul style="list-style-type: none"> • Treatment failure with preferred product. • Contraindication to preferred product. • Allergic reaction to preferred product. Patients on non-preferred therapy will be allowed to continue on that therapy
	ABILIFY (aripiprazole) clozapine GEODON (ziprasidone) RISPERDAL (risperidone) SEROQUEL (quetiapine)	CLOZARIL (clozapine) ZYPREXA (olanzapine)	
	ATYPICAL ANTIPSYCHOTIC/SSRI COMBINATIONS		
		SYMBYAX (olanzapine/fluoxetine)*	
STIMULANTS AND RELATED AGENTS Effective 3/04 PA Implementation 4/28/04	AMPHETAMINES		<ul style="list-style-type: none"> • Treatment failure with preferred product. • Contraindication to preferred product. • Allergic reaction to preferred product.
	ADDERALL XR (amphetamine salt combination) amphetamine salt combination dextroamphetamine	ADDERALL (amphetamine salt combination) DEXEDRINE (dextroamphetamine) DEXTROSTAT(dextroamphetamine)	
	NON-AMPHETAMINE		
	CONCERTA (methylphenidate) FOCALIN (dexmethylphenidate) METADATE CD (methylphenidate) methylphenidate RITALIN LA (methylphenidate)	CYLERT (pemoline) METADATE ER (methylphenidate) pemoline PROVIGIL (modafinil) RITALIN (methylphenidate) RITALIN-SR (methylphenidate) STRATTERA (atomoxetine)	

Children's Medication Algorithm Project (CMAP)

Please use this link to access information regarding CMAP:
<http://www.mhmr.state.tx.us/centraloffice/medicaldirector/CMAP.html>

TRAAY Project

Dr. M. Lynn Crismon, committee member, provided information regarding Treatment Recommendations for the Use of Antipsychotics for Aggressive Youth (TRAAY). Described as a consensus process to develop treatment recommendations for the pharmacotherapy of aggression in youth. TRAAY I is a literature review, and TRAAY II are the treatment recommendations. These documents were provided to the subcommittee chairs and are available upon request.

Appendix C

Comments

Comments of Roy Block:

Mr. Block noted that care should be taken in regard to seeking approval of the biological family for permission to administer any medical treatment including prescribed medications of any nature.

Comments of Dr. Joseph Burkett:

Dr. Burkett expressed disagreement with the decision to not include the following recommendation in the final report.

"The committee recommends that outcomes established to measure the use of psychotropic medications reflect the standards of care recommended in the report, including protocols for prescribing and monitoring, consultation, data collection, and training. In addition, it is critical that outcomes in this area recognize that the use of psychotropic medications is an adjunctive treatment tool, which when used appropriately as a part of a treatment plan, can improve a child's well-being and health (Guiding Principle 2). Outcomes established through contracts or other means must carefully guard against wording that creates incentives to deny care to those who need it, but rather focus on improvements in child functioning."

Dr. Burkett also suggested that the contracts with providers of residential childcare need to be revised to ensure that the contract “does not conflict with current scientific, evidence-based treatment trends.”

Comments of Dr. Lynn Crismon:

Dr. Crismon suggested that the composition of the Clinical Advisory Council be expanded to include one or more board certified psychiatric pharmacists. Dr. Crismon recommended that the term guidelines be used instead of “guidelines and protocols” as the term guidelines is sufficient and is more widely accepted by physicians. In relation to establishing a competency focused training system, Dr. Crismon noted, “most testing only indicates that the individual is competent in taking a test – not in caring for the patients.

Comments of Bonnie Finley:

Bonnie Finley offered several options for monitoring the use of psychotropic medications in foster care. Ms. Finley noted that the treatment team planning process could be used to identify “red flag” cases that would be referred to the CRT. Ms. Finley suggested that the monitoring of appropriate medications could be performed by Youth for Tomorrow (YFT). Ms. Finley also noted that having YFT check these files, would serve as a second opinion to the recommendation already provided by the child’s Treatment Team; but adjustments would need to be made to ensure all case files are reviewed within pre-determined timeframes. Ms. Finley added YFT could “note any ‘Red Flag’ cases and bring them to the attention of the Treatment Team or to the CRT”.

Ms. Finley stated that each Child Placing Agency (CPA) “could address their responsibility for monitoring the training, administering medication, and documentation through their Plan for Compliance. This was a document required by Residential Childcare Licensing (RCCL) in approximately the year 2000. The plan ensures we have procedures and systems in place to self-monitor. The plan requires a component whereby the CPA must evaluate the effectiveness of the self-monitoring. RCCL could review these plans, along with reading children’s files, during their facility inspections.

Ms. Finley noted another way “to monitor a CPA’s Psychotropic Medications Plan and its effectiveness would be through the DFPS Contract that each CPA is required to sign. DFPS contract management staff could review each agency’s adherence to the requirements in the contract. This would not be as an outcome, but as a compliance issue with the requirements of the contract”.

In the area of informed consent Ms. Finley noted that both the child's age and developmental level should be taken into account when involving the child in his treatment plan including the use of psychotropic medications. Ms. Finley also noted there are several unanswered questions: What age and developmental level would a child be allowed to decide on whether or not to take a medication? What happens if a child, who does have the maturity needed to make this decision, refuses to participate?

Ms. Finley expressed a concern regarding the study to examine trends in prescribing psychotropic medications to foster children. Ms. Finley stated, "The study described would not provide the answers being sought. The study is trying to compare two very different child populations. Just because children are on Medicaid does not mean they share the same medical/emotional issues. The recommendation says that poverty appears to be the common factor and somehow links these children; therefore we can compare/contrast them. The trauma of being removed from home, plus coming from an abusive and/or neglectful environment sets foster children apart from any other child population. How can a study begin to compare the emotional state of our foster children with children who are simply living in poverty? Instead, why not fund a study to determine if there is truly a problem with children in foster care being over-medicated. Let's identify the specific problem, if one is found, and deal with that alone."

Comments of Bob Hartman:

Mr. Hartman expressed a concern in relation to the first additional recommendation on page 9 of this report. Mr. Hartman noted that it will be very difficult to find a matched group of Medicaid children similar to the foster care population because of the multiple and complex traumas/multiple diagnoses of children and youth in the foster care system.

Mr. Hartman also recommended that the membership of the Clinical Advisory Council described on page 5 of this report be expanded to include representation from residential childcare agencies/programs.

Comments of Nancy Holman:

Nancy Holman recommended that the membership of the Clinical Advisory Council be expanded to include "professional representation from providers of foster care and residential child care services." Ms. Holman noted that the knowledge and perspective of clinical professionals who provide services to foster children should be represented on the Clinical Advisory Council and Clinical Review Teams.

Comments of Richard LaVallo:

Mr. LaVallo disapproved of the final report. Mr. LaVallo's comments in their entirety are included below:

"Disapproval for the Following Reasons"

As an advocate for foster children with disabilities, I cannot support the Advisory Committee's report. In light of the serious and disturbing findings regarding the use of psychotropic medications for foster children that were made by Comptroller Strayhorn in *Forgotten Children: A Special Report on the Texas Foster Care System*, I strongly believe that more drastic measures must be taken to regulate the use of psychotropic medications for foster children in Texas. Specifically, my objections to the report are as follows:

- 1) The credibility of the report is severely compromised by the Advisory Committee's failure to define the nature and extent of the problems associated with the administration of psychotropic medications in the foster care system. The report should have included data on the number of foster children who receive psychotropic medications; the number of foster children on psychotropic drugs under the age of 6; the number of foster children on 3 or more psychotropic medications; and the number of foster children on 2 or more of the same class of psychotropic medications. The Advisory Committee could have requested this data from the State Medicaid Office's Vendor Drug Program. Without such data, it is impossible for the Advisory Committee to make meaningful recommendations designed to "establish and maintain a process that promotes a model of best practice in regards to the use of psychotropic medications for children and youth in the care of DFPS."
- 2) The Advisory Committee's failure to identify who should be providing informed consent for the administration of psychotropic medications to foster children is very troubling. The report states that the authority to consent to medication "may be exercised directly by DFPS staff or through the delegation of authority to caregivers when appropriate." Even though the DFPS has managing conservatorship of foster children with the power to consent to medical decisions, it is unclear whether this power is delegable to foster parents or other care providers under its existing rule on Medical and Dental Services for Children in Substitute Care, 19 Tex. Admin. Code § 700.1351. Under what circumstances should this decision-making authority be retained by the child's caseworker or delegated to a foster parent or other care provider? If a child is placed in a residential treatment center, would it ever be appropriate for the facility to be able to consent to medications? If a child's caseworker retains the

right to consent to medication, would the legal requirements for informed consent be satisfied by having the caseworker sign a consent form without attending the doctor's appointment in which decisions are made about medications? By ignoring these questions, the Advisory Committee is merely maintaining the confusion of the status quo and not achieving its goal of promoting "a model of best practice in regards to the use of psychotropic medications for children and youth in the care of DFPS."

- 3) Clearly defined informed consent procedures must be established by statute or rule to meet the unique needs of foster children. The child's parent, foster parent, caseworker or any other person designated by the court must have the authority to consent to psychotropic medications. Such persons must successfully complete an administration of psychotropic medication training program and attend in person or participate by telephone in any appointments with the child's physician in which psychotropic medications are prescribed or reviewed. He or she must also be given the child's "medical passport" described in section 7. A care provider must not be allowed to remove a child from his or her foster home or facility because the child or person authorized to consent on behalf of the child refuses to consent to psychotropic medications or withdraws consent to psychotropic medications. Consent must be given in writing and may be revoked at any time.
- 4) The report does not sufficiently identify the type of information that must be provided to the person consenting to medication on behalf of foster children. Given the current public debate over the use of non-FDA approved drugs for children and multiple drug regimens, it is critical that the foster parent, caseworker or other person authorized to consent on behalf of a foster child be provided the following information in simple, nontechnical language that includes:
 - i. A description of the condition and the condition's symptoms exhibited by the child for which the medication is being prescribed;
 - ii. The name of the medication being prescribed, a listing of all other names by which the medication is known, and the requested dosage range of the medication that the physician is prescribing;
 - iii. How the prescribed medication will help the child, and the time by which improvement in the child's symptom is expected;
 - iv. The generally accepted alternatives to the medication, if any, and why the physician recommends they be rejected;

- v. If the medication has been approved by the FDA for this condition. (If not - on what research is the physician relying for choosing this medication?);
- vi. If the medication has been the subject of any FDA alerts and, if so, what was the nature of the alert or caution;
- vii. The side effects that commonly occur with the prescribed medication;
- viii. The rare or serious side effects, if any, that can occur with the prescribed medication;
- ix. Whether the prescribed medication is addictive, and whether it can be abused;
- x. The recommended dosage (or range of dosage) for the prescribed medication, and how often it needs to be taken;
- xi. Whether there are any laboratory tests, including heart testing and blood testing, that need to be done before the child is administered the prescribed medication, and whether any tests will need to be done, and at what time periods, while the child is taking the medication;
- xii. Who will be monitoring the child's response to the prescribed medication, and whether the person will be able to modify the dosage if necessary;
- xiii. How often the child's progress will be checked, and by whom;
- xiv. How long the doctor anticipates the child will need to take the medication, and how the decision will be made to stop the medication;
- xv. Whether there are any other medications (including over-the-counter medications), or any foods, the child should avoid while taking the medications;
- xvi. A listing of all other medications (including over-the-counter medications) the child is currently taking, and whether there are any interactions between any of these medications and the prescribed psychotropic medications. If there are any such interactions, how to avoid them;

- xvii. Whether there are any activities the child should avoid while taking the prescribed medication; and whether there are any precautions recommended for other activities in which the child engages;
 - xviii. What the child's foster parent or care provider is to do if a problem develops, including the child becoming ill, missing doses, or developing side effects; and
 - xix. Whether the child's school nurse, or other school personnel, needs to be informed about the child taking this medication.
- 5) I am very concerned about foster children under the age of 6 being administered psychotropic medications. Safeguards must be instituted to protect against preschool children being unnecessarily medicated and to ensure that other forms of treatment or therapy are provided. This is particularly true since most of the psychotropic medications being prescribed to foster children have not been approved for children by the FDA. Therefore, there should be a rebuttable presumption that the administration of psychotropic medication to a child under 6 is not indicated. If there is a recommendation that a foster child under the age of 6 needs psychotropic medication, the court must approve the administration of psychotropic medications.
- 6) Foster children age 16 and over must be involved in making decisions about psychotropic medications. In order to enhance the likelihood of their compliance with medications, it is imperative that these older foster children participate in the informed consent process and have their concerns and preferences regarding medications be considered by their treating psychiatrist. If a foster child 16 or older refuses to consent to psychotropic medications, the Department should then be required to file a motion with the court for the approval of the administration of psychotropic medications. If the child is not already represented by an attorney ad litem, the court should appoint an attorney ad litem to represent the child. The attorney ad litem must advocate for the child's position regarding treatment with psychotropic medications. The child should also have the opportunity to express his or her preferences regarding the administration of psychotropic medication directly to the court. The court may authorize the administration of the psychotropic medication if the court finds that: (a) the child lacks the capacity to make decisions regarding the administration of psychotropic medications; and (b) the treatment with the proposed medication is in the best interest of the child. A guardian ad litem may be appointed by the court to make a recommendation regarding the administration of psychotropic medication based on the best interest of the child.

- 7) The report should have recommended that every child who is being treated with psychoactive medications have a "medical passport." It is virtually impossible for a psychiatrist or physician to properly prescribe psychotropic medications for a foster child without having a full medical history of the child, especially how the child has responded to particular psychotropic medications in the past. Federal law already requires that a child's medical records pertaining to the child's medications be reviewed and updated and provided to the child's foster parent or care provider at the time of each placement of the child. 42 U.S.C. § 675 (1)(C) & (5)(D). Thus, before the foster parent, caseworker or other person authorized to consent to medication approves the administration of psychotropic medication, a medical passport must be given to him or her.
- 8) The report ignores the role of the court in monitoring the use of psychotropic medications. Under the Texas Family Code, the court which has jurisdiction over the child is required to ensure that the special needs of the child are being met at the six month review hearings. See Tex. Fam. Code §§ 263.306(a)(8)(C); 263.503(4). For a child on medication, this review should encompass the administration of psychotropic medications. To facilitate the court's monitoring of medications, the permanency progress reports or placement review reports filed by the Department must include: information about the child's progress on medications; a description of all other therapy the child is receiving for the condition that necessitated the administration of medication; when the child's physician anticipates the medication will be stopped; and the steps taken by the foster parent or care provider to monitor the side effects of the medication. At the review hearings, the child must be provided the opportunity to express his or her views about being treated with psychotropic medication to the court. If the court has any concerns about the medication, a second opinion may be ordered.
- 9) The report does not adequately address the fact that a significant number of foster children are being prescribed psychotropic medications by physicians who are not trained in child psychiatry. To ensure better outcomes for foster children by utilizing evidence-based medication management, serious consideration must be given to requiring physicians who prescribe psychotropic medications to foster children to follow the children's medication algorithm is being developed for the MHMR system in Texas.

- 10) Many foster children have experienced trauma as a direct result of abuse and neglect. If a foster child does not receive appropriate treatment for the harm caused by trauma, it is likely that there will be an over-reliance upon medications to control the child's behaviors that stem from the abuse or neglect. Even though the report mentions the impact of early childhood trauma on the psychopharmacological treatment of foster children, the advisory committee only recommended that "the effect of using medication with traumatized children" should be included as part of the training for caregivers and case managers. The report is totally devoid of making any recommendations regarding the treatment of children who have been traumatized by abuse. If the Department is serious about establishing limits on the use of psychotropic medications for foster children, it must ensure that foster children who have been victims of trauma receive trauma sensitive programming.

- 11) The report fails to delineate a role for Youth for Tomorrow in monitoring the administration of psychotropic medications to foster children in foster homes and residential treatment centers subject to its review. In January 1997, Youth for Tomorrow ("YFT") prepared a Position Paper on the Use of Medication for Behavior Management in which it expressed concern about "children in conservatorship of TDPRS [who were] prescribed high doses of multiple psychotropic medications in addition to other mood altering medications, such as antidepressants and sedatives, as the primary mode of behavior management." During the committee meetings, the YFT representatives described the rare incidents in which it informally notified the Department about its concerns about the medications being prescribed to foster children. In light of YFT's role in reviewing charts of foster children placed in foster homes and residential treatment centers, formal procedures must be established to ensure that any concerns about the use of psychotropic medications for individual foster children raised by YFT are expeditiously and thoroughly investigated by the Department. The courts having jurisdiction over the children and the attorneys ad litem and guardians ad litem appointed to represent these children should also be provided notice of the YFT concerns.

Comments of Dr. Molly Lopez:

“It is my opinion that the members of the regional Clinical Review Teams should be appointed by HHSC and/or DFPS executives, and that current team members should not have the task of recruiting new participants. This would help to ensure an appropriate range of expertise and diversity of membership.” Dr. Lopez suggested adding to the list of training topics “(1) Any precautions associated with the medication, including what to do if a dose is missed, and (2) What behaviors should be monitored to determine response to the medication and the time frame to expect a response.” Dr Lopez also suggested that the results of the recommended study to examine trends in psychotropic medication use in children in foster care be used to inform the monitoring system and in the creation of “Red Flags”.