

PSYCHOTROPIC MEDICATION AND TEXAS FOSTER CARE



Supreme Court Children's Commission
Psychotropic Medication Round Table
July 6, 2012

Executive Summary

In 2011, the Permanent Judicial Commission for Children, Youth and Families (Children's Commission) was asked by members of its Collaborative Council to examine how judges, the child welfare agency, and other advocates and interested persons could work together to further decrease the use of psychotropic medications by Texas' foster youth.¹ The Children's Commission formed a multi-disciplinary workgroup (Workgroup) led by Judge Diane Guariglia, Associate Judge from the 245th District Court in Harris County, and Dr. James Rogers, Medical Director at the Department of Family and Protective Services (DFPS), to study the psychotropic medication oversight process in Texas, the information-sharing process between the court and the state's many child welfare professionals, and the consent process for psychotropic medications. After meeting for approximately a year on this important but sometimes polarizing issue, the Workgroup determined that an in-depth, facilitated discussion among a larger group of stakeholders would be beneficial.

On July 6, 2012, the Children's Commission, in partnership with DFPS, Casey Family Programs, and the Center for Public Policy Priorities (CPPP), convened a Round Table to discuss the matter. Over 50 judges, attorneys, psychiatrists, child welfare leaders, mental health experts, and advocates attended the Psychotropic Medications Round Table facilitated by former judge Scott McCown.²

During the Round Table, participants discussed the Consent Process, Judicial Review, and Agency Oversight, including a detailed discussion of the Psychotropic Medication Utilization Parameters for Foster Children (Parameters). The participants reviewed current statutes, policies, and practices surrounding the use of psychotropic medications and offered their expertise and insights from the field regarding what is working well and what is not.

There were many concerns regarding the gaps in the system, but also many ideas for improvement. The following issues and suggestions carry varying degrees of support and opposition. They represent possible solutions and innovative ideas gathered from the Workgroup, the Round Table, and subsequent research, discussion, input, and feedback from various interested stakeholders. Although some of the ideas and suggestions will be difficult to implement, investigating the possibilities and benefits is important as Texas continues moving toward a system that is sensitive and responsive to the complex needs of children and youth in foster care.

¹ The Collaborative Council is a multi-disciplinary advisory group appointed by the Children's Commission to advise the Commission on the concerns, events, and innovative ideas emerging from the many stakeholder organizations. Membership includes representatives of foster youth and youth advocates, parents and parent advocate groups, attorneys ad litem, community volunteers, child welfare policy experts, adoption and placement service providers, educators, treatment professionals, and local government.

² See Appendix D.

Issues/Ideas:

1. Define “informed consent” in Chapter 266 of the Texas Family Code.
2. Continue to improve the Medical Consenter process by updating the Medical Consenter training, including information on trauma-informed assessment, history, and treatment.³ Also consider offering and promoting the training to other advocates.
3. Ensure foster youth and biological parents whose rights have not been terminated are included in decision-making, as appropriate. To accomplish this goal, Texas might: (i) create CPS policy requiring consideration of foster youth and biological parents when naming the Medical Consenter, as allowed by the Texas Family Code; and (ii) amend Chapter 266 to require findings of such consideration.
4. Clarify CPS policies to require the identity of the Medical Consenter to be filed with the court within five business days and that the Medical Consenter participate in each medical or other appointment involving the use or consideration of psychotropic medication with the provider of care during the appointment, either in person or by phone.
5. Ensure the youth's transition plan includes education about and resources to support the young adult's ability to manage psychotropic medication usage after exiting foster care.⁴
6. Institute a medication maintenance protocol to monitor physical health implications for foster youth on certain types of medications.
7. Develop and support a resource, such as the health passport, or utilize a web-based program to share information such as the child's history, current symptoms, changes in medication, and prior medical care.
8. Amend the uniform DFPS court report to identify the child's Medical Consenter and a brief summary of any psychotropic medication history.
9. Enhance the Parameters with increased emphasis on psychosocial assessment, non-pharmacologic interventions, monitoring, and required medical follow-up.
10. Change the Parameters' Poly-Pharmacy Threshold from 5 to 4.⁵
11. Ensure the Parameters and other oversight tools are used to monitor psychotropic medications for foster youth who are not a part of STAR Health, such as children placed in Texas through the Interstate Compact on Placement of Children (ICPC) or children who are dually-eligible for Medicaid and Social Security benefits.⁶
12. Develop a Conflict of Interest Form for the Ad Hoc Working Group that reviews and updates the Parameters.⁷

³ DFPS has launched an initiative to transform the Texas child welfare system into a trauma-informed system over the next five years. DFPS does not currently have the infrastructure in place to require statewide screening, assessment and treatment for trauma. However, DFPS envisions an infrastructure that would include: (i) identifying and implementing new screening and assessment processes; (ii) revising policy, contracts, and possibly IT systems; (iii) training stakeholders; (iv) ensuring network adequacy to conduct assessments and provide treatment; and (v) developing and implementing quality monitoring systems. DFPS recently implemented a trauma-informed training on the DFPS public website.

⁴ DFPS has stated it can update processes for transition planning and provide educational materials. STAR Health also has service management in place to assist these youth when they agree to this service.

⁵ The Poly-Pharmacy threshold is the number of medications that trigger an automatic review by STAR Health Staff. DFPS has agreed to work with HHSC to accomplish this goal.

⁶ See Dr. Katherine Barillas, Strengthening Psychotropic Medication Accountability for Children in Foster Care (July 2012) (policy brief for One Voice Texas) (on file with author).

⁷ HHSC has now developed this form. See Appendix A for a list of Ad Hoc Working Group members who drafted the original 2005 Parameters and the 2007 and 2010 editions.

13. Include information on race and ethnicity in DFPS' ongoing data collection regarding psychotropic medications.⁸
14. Continue seeking independent review of the Parameters.
15. Create more awareness of the Parameters among all stakeholders.
16. Amend Chapter 263 of the Family Code to require judicial findings at placement review hearings that the youth has been provided the opportunity to express the youth's views on the medical care being provided.
17. Create CPS policy to require, in non-emergency situations, the consideration and elimination of non-pharmacological treatments and psychosocial interventions prior to the use of psychotropic medication. Further, amend Chapter 263 of the Family Code to require courts to review and make findings that such consideration is occurring.
18. Promote judicial and attorney resources and tools that provide free or low-cost education or assistance regarding the medical consent process and appropriate oversight. For example, the Judicial Psychotropic Medication Oversight Form for Medical Consenters in Appendix C may help ensure informed consent is occurring and promote information sharing among the parties.
19. Consider piloting a psychotropic medications hotline with specialized attorneys and/or psychiatric nurses answering questions regarding Texas' statutes and policies for oversight.
20. Ensure that every child in Permanent Managing Conservatorship be appointed an attorney ad litem or guardian ad litem to augment the oversight process.⁹

⁸ Currently, this would require merging DFPS, HHSC, and STAR Health data.

⁹ In some jurisdictions, Court Appointed Special Advocates (CASAs) have served in this capacity in the past as guardians ad litem to youth in Permanent Managing Conservatorship.

Psychotropic Medication and Texas Foster Care

Introduction

Psychotropic medications are substances that affect the mind and alter mental processes such as perception, mood, and behavior. Psychotropic drugs include stimulants, antidepressants, antipsychotics, and mood stabilizers. These medications are used for the long-term treatment of mental health disorders that are inherited or developed, such as attention deficit hyperactivity disorder, severe depression, or psychosis. Psychotropic medications are also used to help temporarily relieve severe emotional stress and improve day-to-day functioning in school, at home, and in the community. Medication may be beneficial to children and youth in foster care to ameliorate the effects of trauma from exposure to abuse or neglect.

The use of psychotropic medication with children in foster care has become the subject of a heated national debate. Most agree that psychiatric medication may be life-saving and relieve disabling symptoms of mental health disorders. However, studies have shown that adults using these medications may experience serious side effects and little is known about the effects of long-term use in children.

National media has also brought attention to the issue. In early 2012, several articles and a prime time special with ABC's Diane Sawyer portrayed Texas as one of the worst offenders in the over-medication of foster children. These stories focused on a study by the United States Government Accountability Office (GAO) that compared Medicaid data from Texas, Florida, Oregon, Massachusetts, and Maryland. The GAO Study found that among the five states studied in 2008, Texas had the second greatest disparity between the rate of prescriptions filled for psychotropic medications for children in foster care and the rate of similar prescriptions for children who were not in foster care.¹⁰ The GAO report also stated that the high rate may be attributable to the fact that children in foster care have been exposed to trauma stemming from abuse and neglect and have unique challenges with medical care coordination.¹¹ Finally, because the GAO study used 2008 data, the report did not fully capture the progress that has occurred in Texas since 2005. The 79th Legislature enacted Senate Bill 6, which proposed reforms for DFPS, including a plan to place all foster children under a single comprehensive managed care system.¹² As a result of this legislation, STAR Health has provided physical and behavioral health services to children and youth in foster care since April 2008. The 79th Legislature also created Texas Family Code Chapter 266 to govern medical care and education services for children in foster care.¹³ Texas was the first state to create

¹⁰ U.S. GOV'T ACCOUNTABILITY OFFICE, Testimony Before the Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security, Committee on Homeland Security and Governmental Affairs, U.S. Senate, *HHS Guidance Could States Improve Oversight of Psychotropic Prescriptions*, GAO-12-201 (Washington D.C., December 15, 2011).

¹¹ *Id.* at 6, 10.

¹² Senate Bill 6, 79th Leg., R.S., 2005.

¹³ TEX. FAM. CODE ANN. § 266.001 *et seq.* (West 2012).

oversight protocols with the release of the Psychotropic Medication Utilization Parameters for Foster Children (Parameters) in 2005. The Parameters were updated in January 2007 and December 2010.¹⁴

Although there is still much to do, Texas has led the nation in developing tools and resources to improve the way the many child welfare stakeholders work together to decrease reliance on psychotropic medications for children in foster care. Since implementation of the Parameters in 2005, Texas has steadily reduced the use of psychotropic medications in foster care.¹⁵ The U.S. Administration for Children and Families (ACF) recognized Texas as a leader in this area in a 2012 Informational Memorandum regarding the amendments to the Child and Family Services Improvement and Innovation Act, which requires each state to develop “protocols for the appropriate use and monitoring of psychotropic medications.”¹⁶ In the Memorandum, the ACF lists the American Academy of Child and Adolescent Psychiatry, the American Academy of Pediatrics, and the State of Texas as three of the pioneers who in the past decade created practice guidelines for the prescription of psychotropic medications.¹⁷

Texas judges, attorneys, advocates, and child welfare professionals are committed to a continued collaboration to further increase protections for children. The Psychotropic Medication Round Table was opened with a reminder of the common purpose of every participant in the room: to provide foster children the best, most effective and least intrusive treatment for emotional and behavioral difficulties. The discussion was broken down into three parts: Consent, Judicial Review, and Agency Oversight. All of the 50-plus attendees agreed that no one wished to over-medicate or under-medicate children. The difficulty lies in striking a balance and finding the best treatment for each child. Advocating for a child struggling with mental health issues is time and resource-intensive. As reflected in national debate, there are also philosophical, moral, and religious differences about how psychotropic medications should be used with children. Judge McCown challenged the group to not only consider how Texas can improve the process and the system, but also, when the decision-makers disagree, who makes the final decision and how do we get it right for each child?

¹⁴ TEX. HEALTH & HUM. SERV. COMM’N., DEPT. FAM. & PROT. SERV., UNIV. TEX. SCH. OF PHARM., Psychotropic Medication Utilization Parameters for Foster Children, http://www.dfps.state.tx.us/Child_Protection/Medical_Services/guide-psychotropic.asp.

¹⁵ HEALTH & HUM. SERV. COMM’N., Update on the Use of Psychotropic Medications in Texas Foster Children Fiscal Years 2002-2011, http://www.dfps.state.tx.us/Child_Protection/Medical_Services/guide-psychotropic.asp.

¹⁶ ADMIN. CHILDREN, YOUTH & FAMILIES, Information Memorandum: Promoting the Safe, Appropriate, and Effective Use of Psychotropic Medication for Children in Foster Care, Log No: ACYF-CB-IM-12-03, (2012), <http://www.cwla.org/newsletter/MemberConnect/ACYFWaivers.pdf>.

¹⁷ *Id.* at 12.

Round Table Discussion

I. Consent

Consent Process for Children in Foster Care

Consent is defined as the provision of approval or agreement, particularly and especially after thoughtful consideration. Minors typically lack the legal capacity to consent, requiring parents or guardians to serve as consenters on their behalf.

When a child is removed from his or her home, DFPS is named as Managing Conservator and steps into the role of parent, which includes the responsibility of consenting to medical procedures. However, as a governmental agency acting in this role, DFPS may lack valuable historical child and family information to allow for truly informed decision-making, complicating an already difficult situation.

➤ Medical Consenter Must be Designated

The Texas Family Code was amended in 2005 to require consent from a court-authorized Medical Consenter before medical care could be provided to a child in DFPS conservatorship.¹⁸

Texas Family Code Sections 266.004 and 266.010 establish who may serve as the Medical Consenter for a child or youth in DFPS conservatorship as follows:

- foster parent;
- parent whose rights have not been terminated, if in child's best interest;
- DFPS or an agent of DFPS; or
- youth 16 years or older, if the child has capacity to consent.¹⁹

A judge may by court order directly authorize an individual as Medical Consenter or name DFPS as the Medical Consenter. When DFPS is authorized, DFPS must designate an individual who will exercise consent and notify the court within five business days of the designation.²⁰

DFPS prefers to be named as the Medical Consenter because it allows DFPS to replace the designated individual without seeking new court orders. For example, when a youth's residential placement changes or the designated individual is no longer employed by DFPS, has a major illness, or fails to perform his or her duties, the individual may be replaced by filing a form, rather than setting a hearing, providing notice to parties, and requesting new orders. This process can be time-consuming for courts and DFPS staff, and more importantly could delay medical treatment for a child.²¹

Once DFPS is authorized in the order as the Medical Consenter, policy recommends designation of the most appropriate individual, according to the type of placement. When a child is placed in an emergency shelter, DFPS may designate a professional staff member of a General Residential Operation (GRO) Offering Emergency Services (emergency shelter) as either the Medical Consenter or Backup Medical

¹⁸ TEX. FAM. CODE ANN. § 266.004 (West 2012).

¹⁹ TEX. FAM. CODE ANN. §§ 266.004; 266.010 (West 2012).

²⁰ TEX. FAM. CODE ANN. § 266.004(c) (West 2012).

²¹ See DEPT. FAM. & PROT. SERV., Form 2085-b, www.dfps.state.tx.us/applications/forms

Consenter, provided that the staff person is knowledgeable about the child's medical condition and medical care needs. In most cases in which a child has a live-in caregiver, such as a foster parent or kinship caregiver, DFPS designates the live-in caregiver as the Medical Consenter and typically designates a staff member of the Child Placing Agency (CPA) or Child Protective Services (CPS) as Backup Medical Consenter.²² When a child is placed in a Residential Treatment Center (RTC) or Group Home, the CPS caseworker is usually designated as the Medical Consenter, with the caseworker's supervisor as the Backup Medical Consenter. However, if a child is placed in a RTC that is out of the assigned caseworker's region, a caseworker in the region where the child is placed, known as an "I See You" (ISY) worker, becomes the primary Medical Consenter and the home region caseworker or the ISY Supervisor becomes the Backup Medical Consenter.

➤ **Medical Consenter Should Give Informed Consent**

Chapter 266 of the Texas Family Code requires consent for medical care by a Medical Consenter, but does not define consent. DFPS Policy and Training provides more detail about what is required of a Medical Consenter. The CPS Handbook states that, prior to consenting, all Medical Consenters and Backup Medical Consenters must: (i) become knowledgeable about the child's medical condition, history, and needs; and (ii) have completed a DFPS-approved training on medical consent.²³

Family Code Section 266.004 (h) also requires a Medical Consenter to complete a DFPS-approved training program related to "informed consent" and the other mandates under Chapter 266. The only exception to this is for a parent whose rights have not been terminated, unless the Court orders that the parent complete the training.²⁴

Although the term "informed consent," as it relates to medical care for a child in foster care, is not defined in Chapter 266, it is defined in the Texas Administrative Code as it applies to persons admitted to a mental retardation facility, which may be instructive to defining informed consent as it relates to the foster care population.²⁵

The Parameters describe what is meant by "informed consent" by stating that consent to medical treatment in non-emergency situations must be informed consent, which includes discussion of the following with the prescribing doctor/psychiatrist before informed consent may occur:

- a DSM-IV (or current edition) psychiatric diagnosis for which the medication is being prescribed;
- target symptoms;
- treatment goals (expected benefits);
- risks of treatment, including common side effects, laboratory findings, and uncommon but potentially severe adverse events;
- risks of no treatment;
- overall potential benefit to risk of treatment;

²² DEPT. FAM. & PROT. SERV., Child Protective Services Handbook § 11111 (Sept. 2011) available at http://www.dfps.state.tx.us/handbooks/CPS/Files/CPS_pg_x11000.asp#CPS_1111.

²³ *Id.*

²⁴ TEX. FAM. CODE ANN. § 266.004(h) (West 2012).

²⁵ 40 TEX. ADMIN. CODE § 8.203(6) (2004) (Dept. of Aging & Disability Serv.).

- alternative treatments available and/or tried;
- the date the child was first placed in current placement;
- child's current weight in pounds; and
- child's date of birth, as it is necessary to classify the child as a child (age 1-12 years) or as an adolescent (age 13-18 years) because some medications are approved for children but not adolescents and vice versa.

The DFPS Residential Child Care Licensing Minimum Standards sets out similar requirements for GROs which employ or contract with healthcare professionals who prescribe psychotropic medications. Standard 748.2253(a) states that the GRO must provide the Medical Consenter the following in writing or document a discussion with the Medical Consenter or a combination of both before requesting consent:

- (1) The child's diagnosis;
 - (2) The nature of the child's mental illness or condition;
 - (3) An explanation of the purpose of the medication;
 - (4) A description of the benefits expected;
 - (5) A description of any accompanying discomforts and risks, including those which could result from long-term use of the medication, and possible side effects, including side effects that are known to frequently occur in persons, side effects to which the child may be predisposed, and the nature and possible occurrence of irreversible symptoms;
 - (6) A statement of whether the medication is habituating in nature;
 - (7) Alternative interventions to the use of psychotropic medication that have been attempted and that have been unsuccessful;
 - (8) Other alternative treatments or procedures to the use of the psychotropic medication;
 - (9) Risks and benefits of the alternative treatments or procedures;
 - (10) Risks and benefits of not receiving or undergoing a treatment or procedure;
 - (11) An explanation that the person legally authorized to give medical consent may ask questions about the child's response to the medication, and may review daily records on request; and
 - (12) An explanation that the person legally authorized to give medical consent may withdraw consent and request the medication be discontinued at any time.
- (a) The healthcare professional must offer to answer any questions the person legally authorized to give consent has about the medication and the person must sign a consent form that acknowledges [all of

the information set forth in subsection (a) has been provided]. A copy of this signed consent form must be filed in the child's record.²⁶

The DFPS Medical Consent Training defines "Informed Consent" as including a discussion of the following issues with the healthcare provider:

- the nature of the decision or procedure;
- reasonable alternatives to the proposed intervention;
- the relevant risks, benefits, and uncertainties related to each alternative;
- assessment of patient understanding; and
- the acceptance of the intervention by the patient.²⁷

In December 2011, DFPS published an online training on psychotropic medications for DFPS staff, foster parents, and residential providers, which focuses on informed consent.²⁸ The online Psychotropic Medication Training lists the following four expectations of Medical Consenters:

1. Understand that, in most cases, other interventions should be tried before psychotropic medications.
2. Understand the need for a complete psychiatric evaluation prior to giving psychotropic medications.
3. Understand the responsibility of the Medical Consenter to give informed consent for each psychotropic medication prescribed for a child.
4. Understand how psychotropic medications are used.

The Parameters also state that part of the informed consent process is the consideration of alternative treatments and trauma-informed care. The concept of trauma-informed care is relatively new and a huge paradigm shift for the entire foster care system that will take some time to implement. DFPS is currently launching a multi-phased plan to transform the Texas child welfare system into a trauma-informed system of care. Part of this process includes identifying trauma-informed screening/assessment tools and processes and building a network of trained behavioral health providers to provide trauma-informed assessment and treatment services. Trauma-informed therapies and alternative healing practices are often more expensive, more time-consuming, and largely unfamiliar to many caregivers. When trauma-informed practices are not considered, medical consent is less informed. Kinship families also struggle to access the necessary tools and resources that can create a healing environment for the children in their care and help preclude the need for psychotropic medications.

➤ **Medical Consenter Must Participate**

Section 266.004 (i) of the Family Code requires the Medical Consenter to participate in each medical care appointment for the child. According to the CPS Handbook, the appropriate level of participation depends

²⁶ 40 TEX. ADMIN. CODE § 748.2253 (Jan. 1, 2007) (Dept. of Fam. & Prot. Serv., Residential Child Care Licensing Minimum Standards).

²⁷ DEPT. FAM. & PROT. SERV., Medical Consent Training, http://www.dfps.state.tx.us/Child_Protection/Medical_Services/medical-consent-training.asp.

²⁸ DEPT. FAM. & PROT. SERV., Psychotropic Medication Training, http://www.dfps.state.tx.us/Training/Psychotropic_Medication/default.asp (last visited January 1, 2013).

on the nature of the medical care the child is receiving and the requirements of the healthcare provider.²⁹ Certain healthcare providers may require greater participation, including that the individual consenting to medical care attend the appointment in person.³⁰ For preventive care, DFPS policy allows the Medical Consenter or Backup Consenter to provide written consent or authorize another person to take the child to the appointment. For behavioral health therapy (e.g., counseling), the Medical Consenter is required to approve the treatment plan and monitor the progress of the child, but is not required to attend therapy sessions, unless required by the provider. For appointments that involve physical health treatment, such as when the child is sick, dental treatment, or review of the child's progress with psychotropic medications, the Medical Consenter must attend or participate by phone.³¹

Concerns with the Consent Process

Round Table participants offered examples of common problems experienced with the consent process as it relates to the prescription and use of psychotropic medication. It was acknowledged by all that, even under the best of circumstances, with intact families, resources and information, it is still difficult to decide whether psychotropic medications are best for a child. When the complexities of the child welfare system are added, the process becomes even more difficult.

➤ Informed Consent is not Consistently Occurring

Informed consent as it relates to the prescription and use of psychotropic medication envisions that the Medical Consenter will talk to the child's doctor, share necessary information, ask appropriate questions, and ensure that non-pharmacological alternatives are considered. Participants voiced the concern that some foster parents who act as Medical Consenters are not able to give effective informed consent because they lack: (i) an understanding of their role as Medical Consenters and informed consent requirements; (ii) expertise in trauma-informed care and non-pharmacological alternatives to psychotropic medications; and (iii) resources and tools to access alternative treatments. Also, there is an argument that overcrowded foster homes exacerbate the use of psychotropic medications when the need for behavior control becomes paramount.

Medical Consenters sometimes have difficulty questioning physicians about recommended treatment with psychotropic medications. A judicial participant noted that a caseworker in his court who was the Medical Consenter for a child on his docket felt powerless to do anything that contradicted what the psychiatrist was prescribing or suggesting. Consenters must understand that they have been statutorily granted the authority to make certain decisions, as well as the responsibility to ensure consideration of the many safeguards built into the concept of informed consent.

➤ Participation is not Consistently Occurring / Insufficient History

Child psychiatrists reported that they rarely have access to the caseworkers when caseworkers are the Medical Consenters for youth at RTCs and often end up making decisions without CPS input. The greater the

²⁹ DEPT. OF FAM. & PROT. SERV., CPS Handbook, §§ 11122; 11111 (Sept. 2011) available at http://www.dfps.state.tx.us/handbooks/CPS/Files/CPS_pg_x11000.asp#CPS_1111.

³⁰ *Id.*

³¹ *Id.*

separation between the live-in caregiver, who is in the best position to fill the role, and the Medical Consenter, who conveys observations to the prescriber in real time as medication decisions are made, the more difficult it becomes to share information. Some participants of the Round Table were of the opinion that, when the caseworker is the Medical Consenter but does not attend or participate in the appointment, consent is not informed and arguably not given at all. Participants also discussed the importance of the relationship between the prescriber, the patient, and the Medical Consenter, noting that if the Medical Consenter and the doctor develop a good relationship, informed consent is more likely to occur rather than consent as a mere formality.

A child psychiatrist commented during the Round Table that he had experienced very positive outcomes with a DFPS Developmental Disability Specialist serving as the Medical Consenter for all the youth in a facility. The psychiatrist speculated that this allows good working relationships to develop between the Medical Consenter and the psychiatrist because the Medical Consenter gains expertise in best practices for the use of psychotropic medication as he or she becomes very familiar with the foster youth. This comment spurred a discussion around the concept of creating a Medical Consenter position in urban areas whose sole role would be to become an expert on psychotropic medications and to advocate for foster youth.

➤ **Cultural Impact is Often Not Considered**

During the Round Table, there was discussion of the effects of race and ethnicity on the prescribing of psychotropic medications and how this is often not considered by the many professionals who prescribe, consent, oversee, or care for children in foster care. More research and better data collection by race and ethnicity would tell a more complete story and would help identify whether psychiatric diagnoses and prescribing habits are biased. A 2011 groundbreaking analysis of school discipline policies was discussed as an example of how implicit bias can lead to race-based differentiations in treatment.³² The study, *Breaking Schools' Rules*, followed nearly one million 7th graders in Texas public schools for at least six years, finding that where disciplinary action was discretionary, African American students had a 31% higher likelihood of suspension or expulsion as compared to otherwise identical white and Hispanic students.³³

Another study from 2005 examined the relationship between clinician-patient ethnicity and psychiatric diagnoses, raising the question of whether race and culture affected how psychiatrists make diagnoses. The study found that a “lack of familiarity with the cultural rules governing patients’ personal behavior” was a plausible explanation for why “non-Hispanic doctors in the study were more likely to diagnose the Hispanic patients with personality disorders.”³⁴

The Round Table participants also discussed the concern that people of color sometimes receive less effective treatment or are not fully informed when giving consent because of the cultural tendency to refrain from questioning doctors about medications or other medical advice.

³² COUNCIL ST. GOV'TS., PUB. POL. RESEARCH INST., *Breaking Schools' Rules: A Statewide Study on How School Discipline Relates to Students' Success and Juvenile Justice Involvement* (2011), available at <http://justicecenter.csg.org/resources/juveniles>.

³³ *Id.* at 45.

³⁴ ZAYAS, L., CABASSA, L., PEREZ, M., & HOWARD, M. (2005). Clinician-patient ethnicity in psychiatric diagnosis: A pilot study with Hispanics. *Journal of Ethnic & Cultural Diversity in Social Work: Innovation in Theory, Research & Practice*, 104. <http://search.ebscohost.com.library.capella.edu>. Although the study was small, it revealed interesting findings that cultural proximity between patient and clinician affected the diagnoses. Two Hispanic psychiatrists interviewed Hispanic patients and made their own diagnoses. Later, two non-Hispanic psychiatrists watched videos of those interviews and made diagnoses.

➤ **Health Passport not Widely Used / Lacks Information**

Until recently, the electronic health passport was only available to STAR Health staff, DFPS caseworkers, the child's medical consentor, and contracted STAR Health providers. DFPS has now completed statewide implementation of health passport access for select CASA employees. DFPS is also in the process of arranging access for judges via a similar process. In the meantime, DFPS may print the health passport record for a child and make it available to a judge upon request on a case-by-case basis.

Another problem with the passport is that it does not always capture vital information, such as the child's height, weight, and allergies, or any ongoing medical problems, as these are optional pieces of information for a prescriber to enter.³⁵

➤ **Foster Care Payments Not Aligned with Youth Well-Being**

Some participants raised the concern that, under the current system, foster care homes and RTCs are paid a higher reimbursement rate for kids with a higher level of care. This reimbursement structure may motivate caregivers to ask for or encourage doctors to prescribe psychotropic medications for children in their care to receive the higher reimbursement rate. Judge McCown posed the question of whether psychotropic medications are sometimes used when foster homes lack the support, resources, and training needed to deal with the effects abuse and neglect have on the children in their care. One psychiatrist noted his experience has been that the youth are dealing with serious effects of trauma and abuse, sometimes with severe aggression or self-harming behaviors that require medication to stabilize.

Beginning in 2010, DFPS joined other child welfare stakeholders across the state in an effort to redesign the current foster care system. Foster Care Redesign is intended to better align and incentivize improved outcomes for children and youth in foster care by changing the manner in which DFPS procures contracts and pays for foster care services. In the redesigned system, the child or youth's service level will no longer be tied to the rate of reimbursement a residential provider receives from DFPS. DFPS will pay a Single Source Contractor a single blended foster care per diem rate in an effort to better align the financial reimbursement system with the goal of helping children and youth get better and stay better without the fear of placement changes and negative financial impact to the residential provider.

II. Agency Oversight

Oversight Process for Children in Foster Care

Texas was the first state to develop a "best practices" guide for oversight of psychotropic medications for children in foster care. In February 2005, DFPS, the Department of State Health Services (DSHS), and the Health and Human Services Commission (HHSC) released the Psychotropic Medication Utilization Parameters (Parameters). The Parameters serve as a resource for physicians and clinicians who care for children diagnosed with mental health disorders. The Parameters provide recommendations for the appropriate use of psychotropic medications for foster children and include eight criteria indicating need for review of the

³⁵ GAO Study, *supra* note 9, at 24.

child's clinical status.³⁶ Medical Consenters, caregivers, judges, attorneys, and advocates also use the Parameters as they fulfill their duties of advocacy and oversight.

One principle advanced by the Parameters that appears to be overlooked by Medical Consenters and other system advocates is the importance of trauma-informed care. The Introduction and General Principles Section of the Parameters promote a trauma-informed child and family-serving system where all parties involved recognize and respond to the varying impact of traumatic stress on those who have contact with the system. This includes youth, caregivers, and service providers. A robust trauma-informed system would not only screen for trauma exposure and related symptoms, but would also use culturally appropriate, evidence-based assessments and treatment. Medical Consenters must be trained in trauma-informed care in order to play their part in a system that promotes resilience in children and families impacted by and vulnerable to trauma.

➤ **Screening Texas Foster Children on Psychotropic Medications**

STAR Health oversees automated reviews of pharmacy claims data for all children in foster care receiving psychotropic medications to identify medication regimens which appear to be outside the Parameters. Additionally, STAR Health clinical staff routinely conducts telephonic health screenings when children enter DFPS conservatorship or change placements. The telephonic health screening includes screening of children's psychotropic medications regimens. The screening process includes criteria such as:

- **Does the child have a documented mental health diagnosis?**
- **What is the child's age?** (Prescriptions might need further review if the child is under age 3 or 4, depending on the class of medication.)
- **Is the child taking two or more medications from the same drug class?** (Two mood stabilizers and long and short-acting stimulants from the same family are allowed, but otherwise two or more medications from the same class call for further review.)
- **Is the child prescribed five or more psychotropic medications regardless of the class?**

➤ **Psychotropic Medication Utilization Review**

The Psychotropic Medication Utilization Review (PMUR) is designed to determine whether a child's psychotropic medication regimen is outside of the Parameters and, if so, whether a consultation call from a STAR Health child psychiatrist to the prescribing physician is indicated. A PMUR may be initiated by STAR Health if indicated by a health screening or pharmacy claim review. A PMUR may also be triggered by a request from any judge, attorney, caseworker, advocate, foster parent, Medical Consenter, or other concerned person working with the child. The PMUR examines child-specific clinical information about a child's diagnoses, medication dosage, and whether the medication regimen is in compliance with the Parameters. STAR Health has committed to priority responses to inquiries from judges concerning children under their supervision. PMUR findings are usually sent to the child's caseworker or can be faxed or emailed directly to the court if requested.

All PMUR requests are reviewed by one of two STAR Health Licensed Behavior Health Clinicians who gather medical records and screen children's psychotropic medication regimens for compliance with the Parameters. If the regimen is outside the Parameters, the clinician refers the case to a STAR Health child psychiatrist to

³⁶ Psychotropic Medication Utilization Parameters, *supra* note 15.

conduct a PMUR. The child psychiatrist contacts the treating physician, works with the treating physician to reduce poly-pharmacy if indicated, and prepares a PMUR report. The PMUR report will contain a formal determination about the foster child's medication regimen. The possible determinations are as follows:

- Medication regimen within Parameters
- Medication regimen outside Parameters. Medication regimen reviewed and found to be within the standard of care
- Medication regimen outside Parameters, and there is opportunity to reduce poly-pharmacy
- Medication regimen is outside Parameters, and there is risk for or evidence of significant side effects.

STAR Health is well-positioned to intervene and educate the prescribing physician pursuant to its contractual relationship with the physicians. Physicians who appear to consistently prescribe outside the Parameters despite risk for or evidence of significant side effects, or when there is an opportunity to reduce poly-pharmacy, are referred to the Quality of Care (QOC) review process. Additional records are examined for pervasive patterns of over or dangerous prescribing. Qualifying cases are referred to the Credentialing Committee for further investigation and action. The results of Quality Improvement and Credentialing Committee investigations and actions are confidential and may not be released to or discussed with the public. All QOC issues are tracked and trended. Any practitioner showing a pattern or trend may be placed on corrective action and/or face disciplinary action up to and including termination, if warranted.

A PMUR cannot address whether other medications might be effective and this process is not the appropriate avenue to address immediate concerns about new medications or medication side effects; the informed consent process is the appropriate avenue to inquire about new medications and side effects. In these situations, STAR Health recommends that the Medical Consenter contact the prescribing physician directly. DFPS also employs CPS Nurse Consultants in each administrative region to assist CPS staff with children's health issues, including questions about psychotropic medications.

➤ **Judicial Psychotropic Medication Information Line**

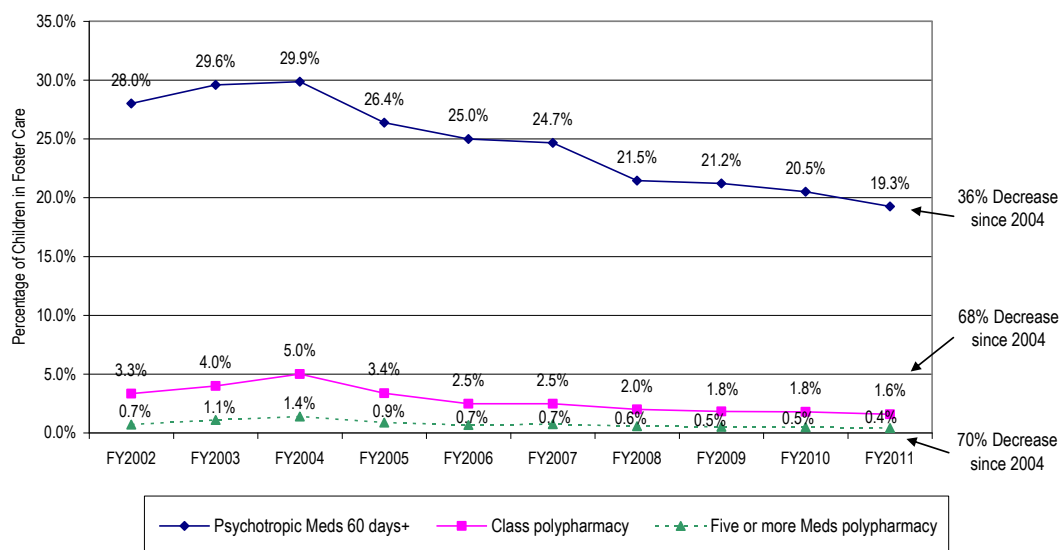
Another tool implemented in 2012 to improve information-sharing is the Judicial Medication Information Email Box, which allows judges to submit a request for general medication information. Emails are reviewed by a STAR Health Behavioral Health Service Manager, who has support from the STAR Health Behavioral Health Medical Director (child psychiatrist), the STAR Health Pharmacist, and clinical managers. An example of an appropriate type of question for the email box is: What are the side effects of a particular medication or combination of medications on a 12-year-old girl who weighs 100 pounds? STAR Health also maintains a 24/7 Behavioral Health hotline with access to behavioral health professionals when urgent needs arise.

➤ **Effect of Texas' Oversight Process**

As a result of the various improvements to Texas' oversight process, including hiring a Medical Director at DFPS, implementing the Parameters as a statewide monitoring system, and launching managed care and clinical consultation by STAR Health, the prescription patterns of psychotropic medications for Texas foster children have improved significantly. Every year, the use of psychotropic medications in Texas foster care

continues to decrease, from 29.9% in Texas State Fiscal Year (FY) 2004 to 19.3% in FY 2011, for children prescribed psychotropic medications for 60 days or more. This decrease represents a 36% reduction in usage.³⁷

FY2002 to FY2011: Percentages of Foster Care Children: receiving psychotropic medication for 60 days or more, two or more medications from the same class, and five or more concurrent prescriptions.



Concerns with the Oversight Process

➤ Integrity of Parameters

Prior to the Round Table, the Commission’s Psychotropic Medication Workgroup convened for several discussions regarding the oversight process in Texas. In early 2012, the State of Texas and Johnson and Johnson, Inc. settled a lawsuit alleging that the pharmaceutical company committed fraud by making false or misleading statements about an anti-psychotic, Risperdal.³⁸ Allegations of inappropriate marketing practices led advocates to worry that such practices might have compromised the integrity of the Parameters. However, the Parameters do not recommend one medication over another, but rather offer guidance on the psychotropic medications commonly used with children and adolescents by providing information on the maximum dosages recommended by the FDA and/or other published studies.

³⁷ Research from Dr. Alan Shafer, Office of Decision Support, Mental Health & Substance Abuse Division, Texas Department of State Health Services, and formerly with the Health and Human Services Commission (2012) (on file with author and DFPS).

³⁸ OFFICE OF THE ATT’Y GEN., Press Release, www.oag.state.tx.us/oagnews/release.php.

To alleviate some of these concerns, DFPS submitted the Parameters to a team of leading experts in the field at Rutgers University to conduct an independent review. This Rutgers Review, included in Appendix B, determined that there was no evidence of bias in the Parameters, but the Parameters could be strengthened by including additional information on evidence-based, non-pharmacological treatments. It also pointed out that greater attention to monitoring health and metabolic status of foster care youth receiving medications is warranted. Following the publication of this review, DFPS stated its general agreement that the evaluation was accurate and contained many reasonable recommendations for how the Parameters and the process could be improved. Further, HHSC agreed at the Round Table to develop a conflict of interest form to be completed by the members of the Ad Hoc group who periodically audit and revise the Parameters.

➤ **Current Parameters Allow Five Psychotropic Medications While Some States Allow Four**

At the Round Table, the participants discussed how the Parameters were created and how the poly-pharmacy trigger point was set at five medications. DFPS confirmed that it set the cutoff at five almost arbitrarily and, as the first state to develop parameters, there was not much research or data to guide this decision. The Rutgers Review suggests that Texas reconsider its initial trigger point and lower it to four. When analyzing 2010 data, DFPS found that of the 47,000 youth in Texas foster care there were 197 youth on five or more medications, 923 on four or more medications, and about 2,800 youth on three or more psychotropic medications.³⁹ DFPS is pursuing this reduction in partnership with HHSC, which controls the content and updating of the Parameters.

➤ **Oversight Structure is Lacking Monitoring System for Trauma-Informed Care**

At the Round Table, participants agreed that Texas' oversight system would benefit from amending the Parameters to include criteria for the consideration and elimination of non-pharmacological treatments and psychosocial interventions prior to consenting to the use of psychotropic medication. In response to these concerns, DFPS began coordinating with STAR Health and HHSC on a plan to implement systems for ensuring that non-pharmacological interventions are considered prior to the use of psychotropic medications, when clinically appropriate.

➤ **Reluctance to Diagnose Too Early**

Another problem discussed at the Round Table was the tension between the Parameter criteria requiring a Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis before prescribing psychotropic medications and the desire to refrain from diagnosing children at too young of an age or too early in the foster care process. The DSM diagnosis requirement is intended to encourage deliberate, thoughtful medication regimens and reduce over-reliance on medications. However, in the recent past, there was a trend to avoid labeling a child with an adult diagnoses and possibly stigmatizing the child for a lifetime. At the Round Table, a judge asked about the diagnoses that contain "NOS." The child psychiatrists in the room educated the participants on its meaning and use, explaining that "not otherwise specified," or NOS, meant the child's symptoms do not fit neatly in the rigid criteria of the DSM. For example, bipolar disorder has certain characteristics and various gradations, but not everyone (especially children) meets the strict

³⁹ Shafer, *supra* note 36.

characteristics of this disorder. The doctors stated that NOS should always accompany another underlying diagnosis, and never stand alone as a diagnosis.

Other Factors May be Influencing the Use of Psychotropic Medications in Foster Care

➤ Texas Foster Children are a More Traumatized Population

The GAO study stated that the high rate of psychotropic medication use in Texas foster care may be attributable to the fact that children in foster care are often exposed to more trauma related to abuse or neglect. Exposure to trauma, coupled with Texas' low removal rate, might indicate that children in Texas foster care have greater mental health needs than other states that have a lower threshold for removal. Texas serves over 75% of families in the home, which means that the children who come into care have typically experienced more severe abuse and neglect and may require more intervention for mental health and behavioral issues.⁴⁰

➤ Limited Mental Health / Substance Abuse Services

Texas ranks 50th in providing adults access to mental health services.⁴¹ Medicaid in Texas is only available to children, the elderly, and the disabled. An able-bodied adult with severe depression or bipolar disorder, who does not have private health insurance, is not likely to access Medicaid. Substance abuse treatment is also unavailable for the majority of the uninsured population. When parents cannot access mental health and substance abuse services, their children often suffer.

Another concern discussed at the Round Table was the lack of access to child psychiatrists for the children and youth in foster care. When child psychiatrists are not available, more primary care physicians are put in the position of prescribing psychotropic medications that may be outside their expertise. STAR Health has made significant strides in contracting with new psychiatrists and other mental health providers, but the large, diverse population and geographic regions in Texas make this challenging.

➤ Limited Trauma-Informed Care/Alternative Treatments

In the general Texas population, about 10% of children are on psychotropic medications compared to 20% of foster kids. The different rates of use could be due to the serious mental health issues that are common with abuse and neglect or the lack of alternative treatments and specialized, trauma-informed services, or a combination of both.

There is general agreement among Texas child welfare stakeholders that trauma-informed care and alternative treatments are integral to reducing the use of psychotropic medication. At the Round Table,

⁴⁰ DEPT. FAM. & PROT. SERV., 2010 Data Book (2010),

http://www.dfps.state.tx.us/documents/about/Data_Books_and_Annual_Reports/2010/2010databook.pdf ; ANNIE E. CASEY FOUNDATION, Texas KIDS Count, (2010), <http://datacenter.kidscount.org/data/bystate/StateLanding.aspx?state=TX>.

⁴¹ THE HENRY J. KAISER FAM. FOUNDATION, State Mental Health Agency (SMHA) Per Capita Mental Health Services Expenditures, FY2010, http://www.statehealthfacts.org/comparable_map_table. (The data are based on an analysis of the Census Bureau's March 2010 and 2011 Current Population Surveys (CPS; Annual Social and Economic Supplements) and are restricted to the civilian (not active duty military) population, representing two-year averages.)

participants noted that the many professionals involved do not always understand how to implement trauma-informed ideas into practice. A child psychiatrist at the Round Table stated that he believes child psychiatrists consider a child's developmental level and the effect of trauma on the symptoms as part of his or her treatment. However, the prescriber may not know if a child is also in psychotherapy or if alternative treatments have been exhausted, which would demonstrate a lack of communication and informed consent between the Medical Consenter and the prescribing doctor. Further, the point was made that even when the professionals involved are educated on the importance of trauma-informed care, the child welfare system struggles to consistently deliver these services.

Part of the DFPS initiative to transform the Texas child welfare system into a trauma-informed system includes coordinating with HHSC and STAR Health to identify evidence-based, trauma-informed treatment strategies and build a network of trained behavioral health providers to offer these services. This initiative includes four subgroups to focus on specific sectors of this work:

1. **Trauma-informed assessments/tools:** develop trauma-informed screening/assessment tools and processes to DFPS leadership;
2. **Trauma-informed training:** develop trauma-informed training for staff and caregivers, including classroom and computer-based applications;
3. **Trauma-informed caregiver support:** develop recommendations and protocols for supporting caregivers, including birth parents, adoptive parents, foster parents, providers, and kin;
4. **Trauma-informed staff support:** develop recommendations and protocols for supporting staff and other stakeholders affected by secondary traumatic stress, direct trauma, compassion fatigue, burnout, and compassion success.

DFPS is currently developing a governance plan to support the Trauma-Informed Care Strategic Plan. This is an ongoing initiative to enhance the well-being of the children and families served along with that of the caregivers and staff providing service. In addition to implementing this strategic plan, DFPS has been working with HHSC and STAR Health to implement systems to ensure that non-pharmacological interventions are considered (when clinically appropriate) prior to prescribing psychotropic medications. As part of this initiative, a study will be conducted to determine the prevalence of cases in which children entering DFPS conservatorship are prescribed psychotropic medications prior to receiving psychotherapy. In some cases, children have been diagnosed with mental health conditions and prescribed psychotropic medications prior to entering DFPS conservatorship. DFPS, HHSC, and STAR Health will explore editing the pharmacy claim audit to trigger first time prescriptions for children not already on psychotropic medications and enhancing telephonic health screening tools. DFPS is also examining the feasibility of amending its Residential Contracts and CPS policy requiring Medical Consenters to consider non-pharmacological interventions, and will develop a written informed consent process that will include this principle and train its staff regarding expectations of compliance with this principle. Other system enhancements may include changes to the Family Code as suggested in the Judicial Review section of this report.

III. Judicial Review

Judicial Review Process

The judiciary is charged with oversight of the safety, permanency, and well-being of the children in their courts. Section 266.007 of the Texas Family Code requires that the judge overseeing the case review a summary of the medical care being provided to the child at each hearing held pursuant to Chapter 263, specifically the permanency and placement review hearings.⁴²

➤ **Court Shall Review Medical Summary**

Chapter 266 states that the summary of medical care provided by DFPS must include:

- The nature of any emergency medical care provided to the child and the circumstances necessitating emergency medical care, including any injury or acute illness suffered by the child;
- All medical and mental health treatment that the child is receiving and the child's progress with the treatments;
- Any medication prescribed for the child and the condition, diagnosis, and symptoms for which the medication was prescribed and the child's progress with the medication;
- The degree to which the child or foster care provider has complied or failed to comply with any plan of medical treatment for the child;
- Any adverse reaction to or side effects of any medical treatment provided to the child;
- Any specific medical condition of the child that has been diagnosed or for which tests are being conducted to make a diagnosis;
- Any activity that the child should avoid or should engage in that might affect the effectiveness of the treatment, including physical activities, other medications, and diet; and
- Other information required by department rule of the court.

With the prescription of psychotropic medication, additional information may be required to effectively oversee that informed consent has been given. Although Chapter 266 requires that judges review the medical care at each hearing conducted under Chapter 263, neither Section 263.302 nor 263.501, which govern permanency and placement review findings, mention medical care.⁴³ As such, there is a disconnect between what judges are required to do in Chapter 266 and the Family Code sections that govern the findings related to review hearings. Chapters 266 and 263 also lack directives to consider whether non-pharmacological treatment and psychosocial interventions have been considered prior to the prescription and use of psychotropic medications.

➤ **Foster Youth and Biological Parents Should be Engaged in the Process**

The Family Code provides that 16 and 17-year-olds may serve as his or her own Medical Consenter with judicial determinations that the youth are capable of the role. If the youth is not the Medical Consenter,

⁴² TEX. FAM. CODE ANN. § 266.007 (West 2012).

⁴³ TEX. FAM. CODE ANN. §§ 263.302; 263.501 (West 2012).

Section 266.007(c) requires that he or she be provided the opportunity to express to the court his or her view on the medical care being provided.⁴⁴ Further, Chapter 263 requires that the youth attend Permanency and Placement Review hearings.⁴⁵ Round Table participants shared concerns about their experiences in child welfare courts where children and youth do not routinely attend their hearings. This is especially concerning with older youth, who are more likely than younger foster youth to be prescribed psychotropic medications. Chapter 266 also allows a court to identify a biological parent as the Medical Consenter, as long as rights have not been terminated.⁴⁶ However, there is no directive in either Chapter 266 or 263 to inquire as to whether the biological parent was considered as the Medical Consenter, whether information about the child's medical treatment while in care has been shared with the biological parent, or any mention of soliciting the biological parent's input into the child's medical care.

➤ **Some Courts Use Standardized Court Report**

In 2012, DFPS adopted a uniform court report which serves as a helpful tool for communication between CPS, the courts, and other parties. The new standardized form provides a summary of medical information that directly follows Section 266.007. The standardized report also includes the child's age and weight, as well as information about medication and dosage, condition and diagnosis, symptom(s) being treated, last medication review, and the prescribing physician. What is not included is the name of the authorized designated Medical Consenter or any psychotropic medication history, although this information may be provided verbally or located elsewhere in the court's file.

➤ **Some Courts Use Specific Informed Consent Forms and Practices**

Some Texas child welfare judges have adopted a practice of ordering that, in non-urgent situations, Medical Consenters must appear in court before giving consent to medication regimens that fall outside the Parameters and other are requesting the Medical Consenter to complete a checklist of questions before appearing in court to help ensure informed consent is occurring.⁴⁷ As part of the work of the Children's Commission Workgroup, STAR Health is evaluating the form reference in Appendix C with the goal of developing a form acceptable to and usable by all stakeholders.

Concerns with the Judicial Review Process

➤ **Separation of Powers**

A point of discussion at the Round Table was whether judges come too close to stepping into the doctor's shoes or becoming the child's Medical Consenter when they overrule a doctor's medical opinion about a psychotropic medication regimen. The standard of review under the Texas Family Code is always the best

⁴⁴ *Id.*

⁴⁵ TEX. FAM. CODE ANN § 263.302; 263.501(f) (West 2012).

⁴⁶ TEX. FAM. CODE ANN § 266.004(e) (West 2012).

⁴⁷ See Appendix C for a sample form used to facilitate this practice.

interest of the child, but how do judges ensure the best interest of the child without running afoul of their role as an independent judicial officer?⁴⁸

Judge McCown posed the question of whether there is a separation of powers issue when no one is questioning or objecting to the care being provided to the child under the direction of the Medical Consenter, who happens to work for the executive branch. What is the role of the independent judiciary if there are no legal questions? The judiciary has the responsibility to check and balance executive power by declaring executive actions unconstitutional where necessary, but what if there are no laws to interpret and no constitutional questions? In that scenario, is a judge prohibited from overruling decisions made about medical care by the executive branch?

Round Table participants posed a question regarding when a medication regimen is within Parameters, but an advocate is concerned because the child appears over-medicated or is having adverse effects. The majority of Round Table participants agreed that, whether a medication regimen is within Parameters, or whether there has been a PMUR, if an advocate expresses concern to the court, the judge has a legitimate dispute and must hear evidence and make a decision in the best interest of the child. The participants were also of the opinion that this could occur at any hearing held under Chapter 263.

The conclusion of several participants was that Section 266.007 of the Family Code directs the judge to review all medical care being provided, including any psychotropic medication regimen, and to question whether the care is appropriate under the circumstances presented. Consequently, when judges decide that the medical care is not in the child's best interest, there is an expectation that the judge will enter orders to address the situation.

➤ **Second Opinions Not Funded**

There was also discussion about the advisability and availability of second opinions when the judge or an interested person has concerns about a medication regimen. Seeking additional consultation is a strategy recommended by the American Academy of Child and Adolescent Psychiatry (AACAP).⁴⁹ However, there is not funding for second opinions outside of STAR Health at this time. There is also no guidance in statute or policy that addresses second opinions and it is generally handled on a case-by-case basis. Ordering second opinions must also be tempered by the consideration that youth have a right to be free from repeated medical and psychological evaluations and examinations.

➤ **Reliable Information to Court is Lacking**

Accurate, detailed information-sharing is often compromised by placement changes and the geographic distance of placements from the courts of jurisdiction. The more placement changes that occur, the more history is lost, making effective judicial oversight more difficult. Moreover, when a child is placed out of his or her home region, a caseworker from the new region, an "I See You" (ISY) worker, is usually designated the primary Medical Consenter, and is required to visit the child and participate in medical appointments.

⁴⁸ TEX. FAM. CODE ANN. § 153.002 (West 2012).

⁴⁹ GAO Study, *supra* note 9, at 19, 25-27. The AACAP guidelines cover four categories. Examples of practices for each category include: (1) consent: identifying caregivers empowered to give consent; (2) oversight: monitoring rates of prescriptions; (3) consultation: providing consultations by child psychiatrists by request; and (4) information: websites about psychotropic drugs for clinicians, foster parents, and other caregivers. AACAP guidelines are available at http://www.aacap.org/galleries/PracticeInformation/FosterCare_BestPrinciples_FINAL.pdf.

Designating the ISY worker as the primary Consenter in that situation promotes informed consent by keeping the Medical Consenter close to the child. However, the ISY worker will not be in court to share the latest information. This naturally presents a gap in the integrity of the information because the sharing between the ISY worker and the caseworker may not be complete or accurate, which is in turn conveyed to the court and other parties participating in legal proceedings in the child's home jurisdiction.

➤ **Individuals Serving as Medical Consenter not Timely Designated**

When DFPS is authorized to consent to medical care and designates a Medical Consenter, the notification to the court is often not sent timely, so the court is not aware of the current Medical Consenter. Also, the standardized court report currently does not include the name of the Medical Consenter or any historical psychotropic medication information, which might improve the flow of information to the court. Round Table participants also urged better communication and collaboration with the education systems. Often referrals for a medical evaluation begin at the schools in an attempt to keep children and youth on a certain academic track.⁵⁰

IV. Conclusion

Texas was among the first states to proactively respond to the over-reliance on psychotropic medications for children in foster care. In 2005, the enactment of Senate Bill 6 created a comprehensive health-care system and many new statutory safeguards regarding the prescription and use of such medications. This sweeping reform, combined with the release of the Psychotropic Medication Utilization Parameters, has steadily reduced the rate of psychotropic medication prescriptions, but the need for more effective oversight mechanisms, efficient information-sharing tools, and rigorous standards for informed consent remains.

This Report summarizes the complexities of those outstanding needs and proposes a range of possible solutions. While not a definitive roadmap, the Report articulates an urgent call to improve medical consent systems, amend the Texas Family Code to increase accountability, and enhance data collection and information sharing to better serve our children's best interests. Of paramount importance to our state is garnering the necessary resources to implement a statewide, trauma-informed approach to serving children, youth, and families involved in the child welfare system. The 28,000-plus foster youth currently in care deserve an accountable and sensitive system of care and Texas must do everything in its power to get it right for each and every child.

⁵⁰ CENTER FOR EFFECTIVE COLLABORATION AND PRACTICE AMERICAN INSTITUTES FOR RESEARCH, *Educational Strategies for Children with Emotional and Behavioral Problems* (Washington, D.C., March 2000) at 7.

Appendix A

**Psychotropic Medication Utilization Parameters
for Foster Children**

Developed by:

***Texas Department of Family and Protective Services
and***

The University of Texas at Austin College of Pharmacy

with review and input provided by:

- Federation of Texas Psychiatry***
- Texas Pediatric Society***
- Texas Academy of Family Physicians***
- Texas Medical Association***

December 2010

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Psychotropic Medication Utilization Parameters for Foster Children

Introduction and General Principles

The use of psychotropic medications by children is an issue confronting parents, other caregivers, and health care professionals across the United States. Foster children, in particular, have multiple needs, including those related to emotional or psychological stress. Foster children typically have experienced abusive, neglectful, serial or chaotic care taking environments. Birth family history is often not available. These children often present with a fluidity of different symptoms over time reflective of past traumatic and reactive attachment difficulties that may mimic many overlapping psychiatric disorders. Establishment of rapport is often difficult. These multiple factors serve to complicate diagnosis. Foster children may reside in areas of the state where mental health professionals such as child psychiatrists are not readily available. Similarly, caregivers and health providers may be faced with critical situations that require immediate decisions about the care to be delivered. For these and other reasons, a need exists for treatment guidelines and parameters regarding the appropriate use of psychotropic medications in foster children.

Because of the complex issues involved in the lives of foster children, it is important that a comprehensive evaluation be performed before beginning treatment for a mental or behavioral disorder. Except in the case of an emergency, a child should receive a thorough health history, psychosocial assessment, mental status exam, and physical exam before the prescribing of psychotropic medication. Psychological testing may be particularly useful in clarifying a diagnosis and informing appropriate treatment. The physical assessment should be performed by a physician or another healthcare professional qualified to perform such an assessment. It is recognized that in some situations, it may be in the best interest of the child to prescribe psychotropic medications before a physical exam can actually be performed. In these situations, a thorough health history should be performed to assess for significant medical disorders and past response to medications, and a physical evaluation should be performed as soon as possible. The mental health assessment should be performed by an appropriately qualified mental health professional or appropriate primary care physician with experience in providing mental health care to children. The child's symptoms and functioning should be assessed across multiple domains, and the assessment should be developmentally appropriate. It is very important that information about the child's history and current functioning be made available to the treating physician in a timely manner, either through an adult who is well-informed about the child or through a comprehensive medical record. It is critical to meet the individual needs of patients and their families in a culturally competent manner. This indicates a need to address communication issues as well as differences in perspective on issues such as behavior and mental functioning. At present there are no biomarkers to assist with the diagnosis of mental disorders, and imaging (e.g., MRI) and other tests (e.g., EEG) are not generally helpful in making a clinical diagnosis of a mental disorder.

The role of non-pharmacological interventions should be considered before beginning a psychotropic medication, except in urgent situations such as suicidal ideation, psychosis, self-injurious behavior, physical aggression that is acutely dangerous to others, or severe impulsivity endangering the child or others; when there is marked disturbance of psychophysiological functioning (such as profound sleep disturbance), or when the child shows marked anxiety, isolation, or withdrawal. Given the unusual stress and change in environmental circumstances associated with being a foster child, counseling or psychotherapy should generally begin before or concurrent with prescription of a psychotropic medication. Patient and caregiver education about the mental disorder, treatment options (non-pharmacological and pharmacological), treatment expectations, and potential side effects should occur before and during the prescription of psychotropic medications. It is recognized that many psychotropic medications do not have Food and Drug Administration (FDA) approved labeling for use in children. The FDA has a statutory mandate to determine whether pharmaceutical company sponsored research indicates that a medication is safe and effective for those indications that are listed in the approved product labeling. The FDA assures that information in the approved product labeling is accurate, and limits the manufacturer's marketing to the information contained in the approved labeling. ***The FDA does not regulate physician and other health provider practice. In fact, the FDA has stated that it does "not limit the manner in which a practitioner may prescribe an approved drug."*** ***Studies and expert clinical experience often support the use of a medication for an "off-label" use.*** Physicians should utilize the available evidence, expert opinion, their own clinical experience, and exercise their clinical judgment in prescribing what is best for each individual patient.

Role of Primary Care Providers

Primary care providers play a valuable role in the care of youth with mental disorders. Not only are they the clinicians most likely to interact with children who are in distress due to an emotional or psychiatric disorder, inadequate numbers of child psychiatrists are available to meet all of the mental health needs of children. Primary care clinicians are in an excellent position to perform screenings of children for potential mental disorders, and they should be able to diagnose and treat relatively straightforward situations such as uncomplicated ADHD, anxiety, or depression. As always, consideration should be given regarding the need for referral for counseling, psychotherapy, or behavioral therapy.

Primary care providers vary in their training, clinical experience, and confidence to address mental disorders in children. Short courses and intensive skills oriented seminars may be beneficial in assisting primary clinicians in caring for children with mental disorders. Active liaisons with child psychiatrists who are available for phone consultation or referral can be beneficial in assisting primary care clinicians to meet the mental health needs of children.

General principles regarding the use of psychotropic medications in children include:

- A DSM-IV (or current edition) psychiatric diagnosis should be made before the prescribing of psychotropic medications.
- Clearly defined target symptoms and treatment goals for the use of psychotropic medications should be identified and documented in the medical record at the time of or before beginning treatment with a

psychotropic medication. These target symptoms and treatment goals should be assessed at each clinic visit with the child and caregiver. Whenever possible, recognized clinical rating scales (clinician, patient, or caregiver assessed, as appropriate) or other measures should be used to quantify the response of the child's target symptoms to treatment and the progress made toward treatment goals.

- In making a decision regarding whether to prescribe a psychotropic medication in a specific child, the clinician should carefully consider potential side effects, including those that are uncommon but potentially severe, and evaluate the overall benefit to risk ratio of pharmacotherapy.
- Except in the case of an emergency, informed consent should be obtained from the appropriate party(s) before beginning psychotropic medication. Informed consent to treatment with psychotropic medication entails diagnosis, expected benefits and risks of treatment, including common side effects, discussion of laboratory findings, and uncommon but potentially severe adverse events. Alternative treatments, the risks associated with no treatment, and the overall potential benefit to risk ratio of treatment should be discussed.
- During the prescription of psychotropic medication, the presence or absence of medication side effects should be documented in the child's medical record at each visit.
- Appropriate monitoring of indices such as height, weight, blood pressure, or other laboratory findings should be documented.
- Monotherapy regimens for a given disorder or specific target symptoms should usually be tried before polypharmacy regimens.
- Doses should usually be started low and titrated carefully as needed.
- Only one medication should be changed at a time, unless a clinically appropriate reason to do otherwise is documented in the medical record. (Note: starting a new medication and beginning the dose taper of a current medication is considered one medication change).
- The use of "prn" or as needed prescriptions is discouraged. If they are used, the situation indicating need for the administration of a prn medication should be clearly indicated as well as the maximum number of prn doses in a day and a week. The frequency of administration should be monitored to assure that these do not become regularly scheduled medications.
- The frequency of clinician follow-up with the patient should be appropriate for the severity of the child's condition and adequate to monitor response to treatment, including: symptoms, behavior, function, and potential medication side effects.
- In depressed children and adolescents, the potential for emergent suicidality should be carefully evaluated and monitored.
- If the prescribing clinician is not a child psychiatrist, referral to or consultation with a child psychiatrist, or a general psychiatrist with significant experience in treating children, should occur if the child's clinical status has not experienced meaningful improvement within a timeframe that is appropriate for the child's clinical response and the medication regimen being used.
- Before adding additional psychotropic medications to a regimen, the child should be assessed for

adequate medication adherence, accuracy of the diagnosis, the occurrence of comorbid disorders (including substance abuse and general medical disorders), and the influence of psychosocial stressors.

- If a medication is being used in a child for a primary target symptom of aggression associated with a DSM-IV nonpsychotic diagnosis (e.g., conduct disorder, oppositional defiant disorder, intermittent explosive disorder), and the behavior disturbance has been in remission for six months, then serious consideration should be given to slow tapering and discontinuation of the medication. If the medication is continued in this situation, the necessity for continued treatment should be evaluated at a minimum of every six months.
- The clinician should clearly document care provided in the child's medical record, including history, mental status assessment, physical findings (when relevant), impressions, adequate laboratory monitoring specific to the drug(s) prescribed at intervals required specific to the prescribed drug and potential known risks, medication response, presence or absence of side effects, treatment plan, and intended use of prescribed medications.

Use of Psychotropic Medication in Preschool Age Children

The use of psychotropic medication in young children of preschool ages is a practice that is limited by the lack of evidence available for use of these agents in this age group. The Preschool Psychopharmacology Working Group (PPWG) published guidelines summarizing available evidence for use of psychotropic medications in this age group (Gleason 2007). The PPWG was established in response to the clinical needs of preschoolers being treated with psychopharmacological agents and the absence of systematic practice guidelines for this age group, with its central purpose to attempt to promote an evidence-based, informed, and clinically sound approach when considering medications in preschool-aged children.

The PPWG guidelines emphasize consideration of multiple different factors when deciding on whether to prescribe psychotropic medications to preschool-aged children. Such factors include the assessment and diagnostic methods utilized in evaluating the child for psychiatric symptoms/illness, the current state of knowledge regarding the impact of psychotropic medication use on childhood neurodevelopmental processes, the regulatory and ethical contexts of use of psychotropic medications in small children (including available safety information and FDA status), and the existing evidence base for use of psychotropic medication in pre-school aged children.

The publication includes specific guidelines and algorithm schematics developed by the PPWG to help guide treatment decisions for a number of psychiatric disorders that may present in preschool-aged children, including Attention-Deficit Hyperactivity Disorder, Disruptive Behavioral Disorders, Major Depressive Disorder, Bipolar Disorder, Anxiety Disorders, Post-Traumatic Stress Disorder, Obsessive-Compulsive Disorder, Pervasive Developmental Disorders, and Primary Sleep Disorders.

The working group's key points and guidelines are similar to the general principles regarding the use of psychotropic medication in children already detailed in this paper. However, the working group's

algorithms put more emphasis on treating preschool-aged children with nonpsychopharmacological interventions (for up to 12 weeks) before starting psychopharmacological treatment, in an effort to be very cautious in introducing psychopharmacological interventions to rapidly developing preschoolers. The working group also emphasizes the need to assess parent functioning and mental health needs, in addition to training parents in evidence-based behavior management, since parent behavior and functioning can have a large impact on behavior and symptoms in preschool-aged children.

Therapeutic Controversies

Antipsychotic selection

Significant controversy exists regarding the use of 2nd generation versus 1st generation antipsychotics. Most of the data supporting no difference in efficacy between these two groups of antipsychotics comes from studies conducted in chronically ill adults with schizophrenia. Most of the controlled studies of the use of antipsychotics to treat behavioral disorders in children have been performed with 2nd generation antipsychotics, with the most evidence for risperidone. The only study comparing a 1st generation antipsychotic versus 2nd generation antipsychotics in youth was conducted in individuals with early onset schizophrenia. The 1st generation agent used in this study was molindone, an infrequently used antipsychotic that is known to be weight neutral or cause weight loss in adults. It is unknown how the results of this study can be extrapolated to the treatment of children with externalizing disorders such as conduct disorder or oppositional defiant disorders – the most common situations in which antipsychotics are prescribed in children.

Antipsychotics vary with regard to their side effect profiles, and side effects are the primary basis for individual medication choice. Second generation antipsychotics are prone to cause significant weight gain in many children, but the risk for the development of weight gain in youth varies significantly among the 2nd generation agents. In a recent study over approximately 11 weeks, the average weight gain was olanzapine (8.5kg), quetiapine (6.1 kg), risperidone (5.3 kg), and aripiprazole (4.4 kg). Olanzapine and quetiapine also caused significant increases in cholesterol and triglycerides, and risperidone increased triglycerides (Correll 2009). First generation antipsychotics are prone to causing extrapyramidal side effects. In particular, youth are especially susceptible to developing acute dystonic reactions from 1st generation antipsychotics. Similarly, 1st generation antipsychotics pose a higher risk for the development of tardive dyskinesia in chronically treated individuals. If antipsychotics are indicated, the clinician should carefully evaluate the individual needs of the child, actively engage the family in decision-making, evaluate overall benefit to risk ratio, and when indicated, choose the antipsychotic that the clinician thinks will be best tolerated by that child.

Depression, Suicidality, and Antidepressants

In October 2003, the FDA released a public health advisory alerting health care professionals to reports of suicidality (suicidal ideation and suicide attempts) in clinical trials of antidepressants in pediatric populations. These reports provided the impetus for a FDA meta-analytic review of short-term clinical trials of

antidepressants in children and adolescents. These analyses involved review, assessment, and reclassification of over 400 case descriptions. This review ultimately resulted in findings of an increased risk of suicidality during the first few weeks of antidepressant treatment. The FDA responded by issuing a *black box warning* in October 2004. The black box warning describes an increased risk of suicidality (suicidal behavior and ideation) for ALL antidepressants used in individuals under the age of 18. The incidence of suicidal ideations and behaviors in these pooled analyses was about 4% for those youth receiving antidepressants compared with 2% on placebo. It is important to note that no completed suicides were reported in any of these trials.

The mortality risk of depression is from suicide. Other major suicide risk factors that should be assessed include: substance abuse, conduct disorder, life stressors (such as legal or disciplinary/school problems), interpersonal losses, family and peer discord, abuse, lack of support, poor interpersonal problem-solving ability, the tendency to respond with hostility or overt aggression to frustration or stress, hopelessness and cognitive distortions. All youth with depression should be monitored carefully for the potential presence of suicidal thoughts or behaviors. This should occur at the time of initial clinical assessment and upon each visit follow-up until depression is no longer present. Assessment of suicidality should include asking questions about ideation and frequency, plans, intention, and potential dangerousness. More frequent visits, combined with follow-up calls as necessary, should be considered along with appropriate review of safety plans. It is noteworthy that in one study, the concomitant use of cognitive behavioral therapy was shown to decrease the incidence of suicidality associated with SSRI use.

Stimulants and growth

Parents and caregivers are often concerned about the possibility that stimulants may adversely affect growth. This is largely related to the fact that, at least short term, stimulants decrease appetite. Although data from different studies are mixed, results from the Multimodal Treatment of ADHD (MTA) study, indicate that weight loss occurred during the first 3-4 months of treatment, but this was followed by a resumption of weight increase. The rate of growth in height decreased by about 1-3 cm/year over the first 1-3 years of medication treatment. However, it should be noted that these decreases in height were only seen in the youth who were adherent with their stimulant medications. Although both advantages and disadvantages are associated with medication holidays or vacations, this has been suggested as one mechanism to minimize potential effects on growth. It is questionable whether the use of stimulants has any effect on ultimate adult height (Vitello 2008; Swanson 2008).

Stimulants and cardiovascular side effects

Both stimulants and atomoxetine cause small but statistically significant increases in blood pressure and pulse rate. However, it is unclear whether these changes are clinically significant. Although case reports of sudden death in children taking stimulants have been reported, a causal link has not been proven (Vitello 2008). However, a recent case control study suggests that there may be an association (Gould 2009). It is thought that underlying cardiac disorders such as serious structural abnormalities, cardiomyopathies, serious heart rhythm disturbances, or other serious cardiac problems may place children at increased risk of sudden death

when stimulants are administered (FDA approved product labeling for Adderall and Concerta, 2008; Perrin 2008). The clinician should conduct a careful history of the child and the family regarding potential heart problems. A thorough physical exam should also be conducted. If the history and physical provide suspicion of a cardiac problem, then an electrocardiogram should be considered before beginning a stimulant. If the child has a known history of a cardiac problem, then a cardiology consult should be considered before beginning a stimulant (Perrin 2008).

Distinguishing between Levels of Warnings Associated with Medication Adverse Effects

Psychotropic medications have the potential for adverse effects, some that are treatment-limiting. Some adverse effects are detected prior to marketing, and are included in product labeling provided by the manufacturers. When looking at product labeling, these adverse effects will be listed in the “Warnings and Precautions” section. As well, the “Adverse Reactions” section of the product labeling will outline those adverse effects reported during clinical trials, as well as those discovered during post-marketing evaluation. Many tertiary drug information resources also report information regarding common adverse effects and precautions for use with psychotropic medications.

At times, post-marketing evaluation may detect critical adverse effects associated with significant morbidity and mortality. The Food and Drug Administration (FDA) may require manufacturers to revise product labeling to indicate these critical adverse effects. If found to be particularly significant, these effects are demarcated by a black box outlining the information at the very beginning of the product labeling, and have, in turn, been named black box warnings. Black box warnings are the strongest warning required by the FDA. It is important for clinicians to be familiar with all medication adverse effects, including black box warnings, in order to appropriately monitor patients and minimize the risk of their occurrence.

The FDA has in recent years taken additional measures to try and help patients avoid serious adverse events. New guides called Medication Guides have been developed, and are specific to particular drugs and drug classes. Medication Guides advise patients and caregivers regarding possible adverse effects associated with classes of medications, and include precautions that they or healthcare providers may take while taking/prescribing certain classes of medications. FDA requires that Medication Guides be issued with certain prescribed drugs and biological products when the Agency determines that certain information is necessary to prevent serious adverse effects, that patient decision-making should be informed by information about a known serious side effect with a product, or when patient adherence to directions for the use of a product are essential to its effectiveness. During the drug distribution process, if a Medication Guide has been developed for a certain class of medications, then one must be provided with every new prescription and refill of that medication.

Copies of the Medication Guides for psychotropic medications can be accessed on the FDA website at:

<http://www.fda.gov/Drugs/DrugSafety/ucm085729.htm>.

Usual Recommended Doses of Common Psychotropic Medications

The attached medication charts are intended to reflect usual doses and brief medication information of commonly used psychotropic medications. The preferred drug list of medications potentially prescribed for foster children is the same as for all other Medicaid recipients.

These are intended to serve as a guide for clinicians. The tables are not intended to serve as comprehensive drug information references or a substitute for sound clinical judgment in the care of individual patients, and individual patient circumstances may dictate the need for the use of higher doses in specific patients. In these cases, careful documentation of the rationale for the higher dose should occur, and careful monitoring and documentation of response to treatment should be observed.

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

See Medication Charts beginning on page xx.

Criteria Indicating Need for Further Review of a Child's Clinical Status

The following situations indicate a need for further review of a patient's case. These parameters do not necessarily indicate that treatment is inappropriate, but they do indicate a need for further review.

For a child being prescribed a psychotropic medication, any of the following suggests the need for additional review of a patient's clinical status:

1. Absence of a thorough assessment of DSM-IV diagnosis in the child's medical record
 2. Five (5) or more psychotropic medications prescribed concomitantly (side effect medications are not included in this count)
 3. Prescribing of:
 - (a) Two (2) or more concomitant antidepressants (if an additional one is used, may be reviewed but will be allowed if reasonable for the indications)
 - (b) Two (2) or more concomitant antipsychotic medications
 - (c) Two (2) or more concomitant stimulant medications¹
 - (d) Three (3) or more concomitant mood stabilizer medications
- NOTE: For the purpose of this document, polypharmacy is defined as the use of two or more medications for the same indication (i.e., specific mental disorder).
- ¹ The prescription of a long-acting stimulant and an immediate release stimulant of the same chemical entity (e.g., methylphenidate) does not constitute concomitant prescribing.
- ² When switching psychotropics, medication overlap and cross-titration may be utilized before discontinuing the first medication
4. The prescribed psychotropic medication is not consistent with appropriate care for the patient's diagnosed mental disorder or with documented target symptoms usually associated with a therapeutic response to the medication prescribed.
 5. Psychotropic polypharmacy for a given mental disorder is prescribed before utilizing psychotropic monotherapy.
 6. The psychotropic medication dose exceeds usual recommended doses.
 7. Psychotropic medications are prescribed for children of very young age, including children

receiving the following medications with an age of:

- Antidepressants: Less than four (4) years of age
- Antipsychotics: Less than four (4) years of age
- Psychostimulants: Less than three (3) years of age

8. Prescribing by a primary care provider who has not documented previous specialty training for a diagnosis **other** than the following (unless recommended by a psychiatrist consultant):

- Attention Deficit Hyperactive Disorder (ADHD)
- Uncomplicated anxiety disorders
- Uncomplicated depression

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Recommendations for primary care providers on when to seek referral or consultation with a child psychiatrist can be found at

http://www.aacap.org/cs/root/physicians_and_allied_professionals/when_to_seek_referral_or_consultation_with_a_child_and_adolescent_psychiatrist

Stimulants (for treatment of ADHD)

Drug	Starting Dose	Literature Based Maximum Dosage	FDA Approved Maximum Dosage for Children and Adolescents	Schedule	Black Box Warning *	Warnings and Precautions
Amphetamine Mixed Salts <i>Generic available</i> Adderall® Adderall®XR **	5 mg/day	40 mg/day 30 mg/day-XR	Adderall approved for children 3 years and older: 40 mg/day Adderall®XR approved for children 6 years and older: 30 mg/day-XR	IR: Once or twice daily XR: Once daily	Abuse potential Sudden death and serious cardiovascular events	<ul style="list-style-type: none"> • Sudden death in those with pre-existing structural cardiac abnormalities or other serious heart problems • Hypertension • Psychiatric adverse event • Long-term growth suppression
Dextroamphetamine <i>Generic available</i> Dexedrine® Dexedrine Spansule®	5 mg/day	40 mg/day	Approved for children 6 years and older 40 mg/day	IR: Once or twice daily Spansule: Once daily		
Lisdexamfetamine Vyvanse®	30mg/day	70mg/day	Approved for children 6 years and older 70mg/day	Once daily		
Methylphenidate <i>Generic available</i> Ritalin® Ritalin®SR Ritalin®LA Metadate® Metadate®CD Methylin®	Ritalin IR: 10 mg/day Ritalin SR: 5 mg/day Ritalin LA: 20 mg/day	60 mg/day (30mg/day-	Approved for children 6 years and older Ritalin, Metadate, and Methylin: 60 mg/day Concerta:	Ritalin IR: One to three times daily Ritalin SR: Once daily Metadate: Twice daily		

Drug	Starting Dose	Literature Based Maximum Dosage	FDA Approved Maximum Dosage for Children and Adolescents	Schedule	Black Box Warning *	Warnings and Precautions
Methylin®ER Concerta® Daytrana® TD	Metadate: 10mg/day Methylin: 10mg/day Concerta: 18mg/day DaytranaT D: 10 mg/day	Daytrana TD) (90mg/day- Concerta)	Children: 54 mg/day Adolescents: 72 mg/day Daytrana: 30 mg/day (largest patch)	Metadate CD: Once daily Methylin: Twice daily Methylin ER: Once daily Concerta: Once daily Daytrana TD: Once daily		
Dexmethylphenidate Focalin® Focalin® XR	5 mg/day	20 mg/day	Approved for children 6 years and older Focalin 20 mg/day Focalin XR 30 mg/day	IR: Twice daily XR: Once daily		

* See the FDA approved product labeling for each medication for the full black box warnings.

** IR, immediate-release; SR, sustained-release formulation; CD, combined immediate release and extended release; ER and XR, extended-release; TD, transdermal.

Other ADHD Treatments

Drug	Starting Dose	Literature Based Maximum Dosage	FDA Approved Maximum Dosage for Children and Adolescents	Schedule	Baseline/Monitoring	Black Box Warning	Warnings and Precautions
<p>Atomoxetine</p> <p>Strattera®</p>	<p>Children: 0.5 mg/kg/day</p> <p>Adolescents: 40 mg/day</p>	<p>Children: 1.4 mg/kg/day</p> <p>Adolescents: 80-100 mg/day</p>	<p>Approved for treatment of ADHD (6-17 years)</p> <p>Maximum dosage should not exceed 1.4 mg/kg/day or 100 mg/day, whichever is less</p>	<p>Once or twice daily</p>	<p>None</p>	<p>Suicidal thinking in children and adolescents being treated for ADHD</p>	<ul style="list-style-type: none"> • Liver injury • Serious cardiovascular events, including sudden death, particularly in those with pre-existing structural cardiac abnormalities or other serious heart problems • Increases in blood pressure and heart rate • Psychiatric adverse events
<p>Clonidine</p> <p>Generic available</p> <p>Catapres® (immediate release)</p> <p>Kapvay® (extended release)</p>	<p>IR 0.05 mg/day</p> <p>ER 0.1 mg/day</p>	<p>0.4 mg/day</p>	<p>Immediate release not approved for children and adolescents</p> <p>Extended release (brand name Kapvay®) approved for treatment of ADHD in pediatric patients (6-17 years) up to 0.4 mg/day</p>	<p>IR: Once to four times daily</p> <p>ER: Once or twice daily</p>	<p>None</p>	<p>None</p>	<ul style="list-style-type: none"> • Sedation • Hypotension • Do not discontinue abruptly
<p>Guanfacine</p> <p>Generic available</p> <p>Tenex® (immediate release)</p> <p>Intuniv® (extended)</p>	<p>IR 0.5 mg/day</p> <p>ER 0.05</p>	<p>4 mg/day</p>	<p>Immediate release not approved for children and adolescents</p> <p>Extended release (brand name Intuniv™) approved for treatment of ADHD in pediatric patients (6-17 years) up to 4mg/day</p>	<p>IR: Once to four times per day</p> <p>ER: Once daily</p>	<p>None</p>		

Drug	Starting Dose	Literature Based Maximum Dosage	FDA Approved Maximum Dosage for Children and Adolescents	Schedule	Baseline/ Monitoring	Black Box Warning	Warnings and Precautions
release)	mg/kg/day						
Bupropion Generic available Wellbutrin® Wellbutrin®SR Wellbutrin®XL	Children: 75 mg/day Adolescents: 100-150 mg/day	The lesser of: 3-6 mg/kg/day OR 400 mg/day (SR) 450 mg/day (XL)	Not approved for children and adolescents	IR: Once to three times daily SR: Once to twice daily XL: Once daily	None	Increased risk of suicidal thinking and behavior (suicidality) in short-term studies in children and adolescents with major depressive disorder (MDD) and other psychiatric disorders	<ul style="list-style-type: none"> • Use in combination with MAOIs • Suicidal ideation • Activation of mania/hypomania • Discontinuation syndrome • Increased risk of bleeding
Imipramine Generic available Tofranil®	1 mg/kg/day	4 mg/kg/day OR 300 mg/day (Adolescents)	Approved for treatment of enuresis in children 6 years and older 2.5 mg/kg/day	Twice daily	<ul style="list-style-type: none"> • Pulse • ECG 		
Nortriptyline Generic available Aventyl® Pamelor® Nortrilen®	0.5 mg/kg/day	2.5 mg/kg/day OR 150 mg/day (Adolescents)	Not approved for children and adolescents	Twice daily	<ul style="list-style-type: none"> • Pulse • ECG 		

Antidepressants, SNRIs

Drug	Starting Dose	Literature Based Maximum Dosage	FDA Approved Maximum Dosage for Children and Adolescents	Schedule	Patient Monitoring Parameters	Black Box Warning	Warnings and Precautions
Venlafaxine Extended Release Effexor XR®	Children: Insufficient Evidence Adolescents: Insufficient Evidence	Children: Insufficient Evidence Adolescents: Insufficient Evidence	Not approved for children and adolescents	Insufficient Evidence	1) Pregnancy test – as clinically indicated. 2) Blood pressure during dosage titration and as clinically necessary 3) Monitor for emergence of suicidal ideation or behavior	Increased the risk of suicidal thinking and behavior (suicidality) in short-term studies in children and adolescents with major depressive disorder (MDD) and other psychiatric disorders	<ul style="list-style-type: none"> • Use in combination with MAOIs • Suicidal ideation • Activation of mania/hypomania • Discontinuation syndrome • Increased risk of bleeding
Duloxetine Cymbalta®	Children: Insufficient Evidence Adolescents: Insufficient Evidence	Children: Insufficient Evidence Adolescents: Insufficient Evidence	Not approved for children and adolescents	Insufficient Evidence	1) Pregnancy test – as clinically indicated 2) Blood pressure prior to initiating treatment, during dosage titration, and as clinically indicated 3) Hepatic function testing – baseline and as clinically indicated 4) Monitor for emergence of suicidal ideation or behavior		
Desevenlafaxine Pristiq®	Children: Insufficient Evidence Adolescents: Insufficient Evidence	Children: Insufficient Evidence Adolescents: Insufficient Evidence	Not approved for children and adolescents	Insufficient Evidence	1) Pregnancy test – as clinically indicated 2) Blood pressure prior to initiating treatment, during dosage titration, and as clinically indicated 3) Hepatic function testing – baseline and as clinically indicated 4) Monitor for emergence		

Drug	Starting Dose	Literature Based Maximum Dosage	FDA Approved Maximum Dosage for Children and Adolescents	Schedule	Patient Monitoring Parameters	Black Box Warning	Warnings and Precautions
					of suicidal ideation or behavior		

From Black Box Warning on package inserts: Patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber. Both patients and families should be encouraged to contact the clinician if depression worsens, the patient demonstrates suicidal behavior or verbalizations, or if medication side effects occur. The appropriate utilization of non-physician clinical personnel who are knowledgeable of the patient population can aid in increasing the frequency of contact between the clinic and the patient/parent.

Antipsychotics: Second Generation (Atypical) †

Drug	Starting Dose	Literature Based Maximum Dosage	FDA Approved Maximum Dosage for Children and Adolescents	Schedule	Patient Monitoring Parameters	Black Box Warning	Warnings and Precautions
Aripiprazole Abilify®	Children: 2.5 mg/day Adolescents: 5 mg/day	Children: 15mg/day Adolescents: 30mg/day	Approved for Bipolar Mania or Mixed Episodes in pediatric patients (10 to 17 years) and Schizophrenia in adolescents (13-17 years) 30mg/day Irritability associated with autistic disorder (6-17 years) 15mg/day	Once daily	1) CBC as indicated by guidelines approved by the FDA in the product labeling. 2) Pregnancy test – as clinically indicated 3) Weight and BMI measurement – when a new antipsychotic is initiated, at every visit (monthly for inpatients) for 6 months after the new antipsychotic is initiated, and quarterly when the antipsychotic does is stable. 4) Fasting plasma glucose level or hemoglobin A1c – before initiating a new antipsychotic, then yearly.	Not approved for depression in under age 18. Increased the risk of suicidal thinking and behavior in short-term studies in children and adolescents with major depressive disorder and other psychiatric disorders	<ul style="list-style-type: none"> • Neuroleptic Malignant Syndrome • Tardive Dyskinesia • Hyperglycemia and Diabetes Mellitus • Weight gain • Akathisia • Dyslipidemia
Quetiapine Seroquel®	Children: 12.5 mg/day Adolescents: 25 mg/day	Children: 300 mg/day Adolescents: 600 mg/day	Approved Bipolar Mania (10-17 years) and for Schizophrenia in adolescents (13-17 years) 600mg/day Not approved for children	Once to twice daily	If a patient has significant risk factors for diabetes and for those that are gaining weight – before initiating a new antipsychotic, 4 months after starting an antipsychotic, and then yearly.		
Olanzapine Zyprexa®	Children: 2.5 mg/day Adolescents: 2.5-5 mg/day	Children: 12.5 mg/day Adolescents: 30 mg/day	Approved for Bipolar Mania or Mixed Episodes and Schizophrenia in adolescents (13-17 years) 20mg/day Not approved for children	Once to twice daily	5) Lipid screening [total cholesterol, low-and high-density lipoprotein (LDL and HDL) cholesterol, and triglycerides] – Every 2 years or more often if lipid levels are in the normal range, every 6 months if the LDL level is > 130 mg/dl		
Risperidone Generic available Risperdal®	Children: 0.25 mg/day Adolescents: 0.5 mg/day	Children: 3 mg/day Adolescents: 6 mg/day	Approved for Bipolar Mania or Mixed Episodes in children and adolescents (10-17 years) and Schizophrenia in adolescents (13-17 years) 6 mg/day Irritability associated with Autistic Disorder (5-16 years) 3 mg/day	Once to twice daily			

Drug	Starting Dose	Literature Based Maximum Dosage	FDA Approved Maximum Dosage for Children and Adolescents	Schedule	Patient Monitoring Parameters	Black Box Warning	Warnings and Precautions
Clozapine Generic available Clozaril® Fazaclo®	Children: 6.25-12.5 mg/day Adolescents: 6.25-25 mg/day	Children: 150-300 mg/day Adolescents: 200-600 mg/day	Not approved for children and adolescents	Once daily	6) Sexual function inquiry – inquire yearly for evidence of galactorrhea/gynecomastia, menstrual disturbance, libido disturbance or erectile/ejaculatory disturbances in males. If a patient is receiving an antipsychotic known to be associated with Prolactin elevation, then this inquiry should be done at each visit (quarterly for inpatients) for the first 12 months after starting an antipsychotic or until the medication dose is stable and then yearly. 7) EPS Evaluation (examination for rigidity, tremor, akathisia) – before initiation of any antipsychotic medication, then weekly for the first 2 weeks after initiating treatment with a new antipsychotic or until the dose has been stabilized and weekly for 2 weeks after a dose increase. 8) Tardive Dyskinesia evaluation – every 12 months. For high risk patients (including the elderly), every 6 months. 9) Vision questionnaire – ask whether the patient has experienced a change in vision and should specifically ask about distance vision and blurry vision – yearly 10) Ocular evaluations –	Agranulocytosis; seizures; myocarditis; other adverse cardiovascular and respiratory effects	
Asenapine (sublingual) Saphris®	Insufficient Evidence	Insufficient Evidence	Not approved for children and adolescents	Insufficient Evidence		None related to youth	
lloperidone Fanapt®	Insufficient Evidence	Insufficient Evidence	Not approved for children and adolescents	Insufficient Evidence		None related to youth	<ul style="list-style-type: none"> • Neuroleptic Malignant Syndrome • Tardive Dyskinesia
Paliperidone Invega®	Insufficient Evidence	Insufficient Evidence	Not approved for children and adolescents	Insufficient Evidence		None related to youth	<ul style="list-style-type: none"> • Hyperglycemia and Diabetes Mellitus • Weight gain • Akathisia • Dyslipidemia
Ziprasidone Geodon®	Children: 10 mg/day Adolescents: 20 mg/day	Children: Insufficient Evidence Adolescents: 160 mg/day	Not approved for children and adolescents	Twice daily (Better absorbed when taken with food)		Not approved for depression in under age 18. Increased the risk of suicidality in short-term studies in children and adolescents with major depressive disorder and other psychiatric disorders	<ul style="list-style-type: none"> • Prolonged QTc interval

Drug	Starting Dose	Literature Based Maximum Dosage	FDA Approved Maximum Dosage for Children and Adolescents	Schedule	Patient Monitoring Parameters	Black Box Warning	Warnings and Precautions
					every 2 years in youth ‡ ¶ EKG – Baseline and as clinically indicated (Asenapine, Iloperidone, Paliperidone and Ziprasidone) §		

+ Dosage recommendations in this table are based on reference # 17 (Jensen, 2010).

‡ There is no current clinical consensus regarding the need for routine ocular evaluations in children and adolescents. Data from animal studies suggest that quetiapine might be associated with increased risk of cataract development, but this has not been concluded from current evidence in human use.

§ There is no current clinical consensus regarding the need for routine monitoring of QTc interval with use of Ziprasidone in children and adolescents. For additional information regarding EKG monitoring with Ziprasidone use, please refer to reference # 4 (Blair, 2005).

Antipsychotics: First Generation (Typical)

Drug	Starting Dose	Literature Based Maximum Dosage	FDA Approved Maximum Dosage for Children and Adolescents	Schedule	Black Box Warning	Warnings and Precautions
Chlorpromazine <input type="checkbox"/> Generic available Thorazine®	Child 0.275 mg/kg Adolescent 12.5 mg	Children younger than 5 years 40 mg/day Children 5-12 years 75mg/day Adolescent 800 mg/day	Approved for treatment of severe behavioral problems in children (6 months to 12 years) Outpatient Children: 0.25mg/pound every 4-6 hours Inpatient Children: 200mg/day in older children Adolescents 800 mg/day	Two to four times daily	None related to youth	<ul style="list-style-type: none"> • May alter cardiac conduction • Sedation • Orthostatic hypotension • EPS • Tardive Dyskinesia • Neuroleptic Malignant Syndrome • Use caution with renal disease, seizure disorders, respiratory disease, and any acute illness in children • Weight gain
Haloperidol <input type="checkbox"/> Generic available Haldol®	<35 kg: 0.25-0.5mg/day ≥35 kg: 1 mg/day	<35 kg: 3-4 mg/day ≥35 kg: 10 mg/day	Approved for treatment of Psychotic Disorders, Tourette's Disorder, and severe behavioral problems in children 3 years and older Psychosis: 0.15mg/kg/day Tourette's and severe behavioral problems: 0.075mg/kg/day 6mg/day	Once to three times daily	None related to youth	<ul style="list-style-type: none"> • Sedation • Orthostatic Hypotension • EPS • Photosensitivity • Tardive Dyskinesia • Constipation • Dry Mouth • Tachycardia • Prolactin elevation
Perphenazine Generic Available Trilafon®	≥ 12 years old 12 mg/day	6-12 years: 6 mg/day Adolescents: 64 mg/day	Approved for treatment of psychotic disorders in 12 years and older 64mg/day	Three times a day	None related to youth	<ul style="list-style-type: none"> • EPS • Tardive Dyskinesia • Dystonia • Neuroleptic Malignant Syndrome

Drug	Starting Dose	Literature Based Maximum Dosage	FDA Approved Maximum Dosage for Children and Adolescents	Schedule	Black Box Warning	Warnings and Precautions
						<ul style="list-style-type: none"> • Orthostatic hypotension • May alter cardiac conduction • Endocrine changes • Weight gain
<p>Pimozide Orap®</p>	<p>1-2 mg/day</p>	<p>≤ 12 years 0.2 mg/kg/d 10 mg/day</p>	<p>Approved for treatment of Tourette's Disorder in 12 years and older 10mg/day</p>	<p>Once to twice daily</p>	<p>None related to youth</p>	<ul style="list-style-type: none"> • EPS • Tardive Dyskinesia • Dyskinesias • Dry Mouth • Constipation • Prolactin Elevation • Prolongs QTc interval

☐ Chlorpromazine and Haloperidol, when prescribed for severe behavioral problems, should be reserved for children with who have failed to respond to psychotherapy or medications other than antipsychotics.

Mood Stabilizers

Drug	Starting Dose	Target Dose or Range	Literature Based Maximum Dosage	FDA Approved Maximum Dosage for Children and Adolescents	Schedule	Baseline Monitoring	Black Box Warning	Warnings and Precautions
<p>Carbamazepine</p> <p>Generic available</p> <p>Carbatrol®</p> <p>Tegretol®</p> <p>Tegretol® XR</p>	<p>Under 6 years: 10-20mg/kg/day</p> <p>6-12 years: 100mg twice a day</p> <p>12 years and older: 200mg twice a day</p>	<p>Under 6 years: 35mg/kg/day</p> <p>6-12 years: 400-800mg/day</p> <p>12 years and older: 800-1200mg/day</p>		<p>Approved for Seizure Disorders in all ages</p> <p>Maximum dosages</p> <p>Under 6 years: 35 mg/kg/day</p> <p>6-12 years: 800mg/day</p> <p>12-15 years: 1000 mg/day</p> <p>>15 years: 1200 mg/day</p>	<p>Immediate Release two to four times a day</p> <p>Sustained Release (XR) twice a day</p>	<ul style="list-style-type: none"> • CBS • Electrolytes 	<p>Stevens-Johnson syndrome</p> <p>Aplastic Anemia/Agranulocytosis</p>	<ul style="list-style-type: none"> • Aplastic Anemia • Neutropenia • Hyponatremia • Induces metabolism of itself and some other drugs • Decreased efficacy of oral contraceptives • Teratogenicity • Stevens-Johnson Syndrome
<p>Divalproex Sodium</p> <p>Generic available</p> <p>Depakote®</p>	250mg/day	500mg-2000mg/day	<p>Range: 50-120 mcg/ml</p> <p>Frequency: Day 7</p> <ul style="list-style-type: none"> • Weekly until stable • q6 months thereafter 	<p>Approved for Seizure Disorders in 10 years and older</p> <p>Maximum dose based upon serum level.</p> <p>Serum level: 50-100 mcg/ml or 60 mg/kg/day</p>	Two to three times daily	<ul style="list-style-type: none"> • Chemistry Panel • CBC (with platelets) • LFTs • Pregnancy test 	Hepatotoxicity ; Teratogenicity; Pancreatitis	<ul style="list-style-type: none"> • Hepatotoxicity • Teratogenicity • Pancreatitis • Urea cycle disorders • Multi-organ hypersensitivity reaction • Thrombocytopenia • Withdrawal seizures • Suicidal ideation • Polycystic

Drug	Starting Dose	Target Dose or Range	Literature Based Maximum Dosage	FDA Approved Maximum Dosage for Children and Adolescents	Schedule	Baseline Monitoring	Black Box Warning	Warnings and Precautions
								ovaries
<p>Lithium</p> <p>Generic available</p> <p>Eskalith®</p> <p>Eskalith®CR</p> <p>Lithobid®</p>	<p>Children: 15-20 mg/kg/day in two to three divided doses</p> <p>Adolescents: 300mg three time daily (or 900mg/day)</p>	<p>Dose adjustment based upon serum level.</p> <p>Serum level: 0.4-0.6 mEq/L</p> <p>Note: 300mg Lithium Carbonate increases serum level by 0.2 – 0.4mEq/L</p>	<p>Maximum dose based upon serum level.</p> <p>Serum level: 0.6 – 1.2 mEq/L</p> <p>Frequency of blood level monitoring:</p> <ul style="list-style-type: none"> • Day 7 • Weekly until stable • q3 months thereafter 	<p>Approved for manic episodes and maintenance of Bipolar Disorder in 12 years and older</p> <p>Maximum dose</p> <p>Serum level: 1.2 mEq/L</p>	<p>Once to three times daily</p>	<ul style="list-style-type: none"> • Chemistry Panel • CBC (with platelets) • Serum Creatinine • TFTs • Pregnancy test • ECG 	<p>Toxicity above therapeutic serum levels</p>	<ul style="list-style-type: none"> • Toxicity above therapeutic serum levels • Renal function impairment • Special risk patients: those with significant renal or cardiovascular disease, severe debilitation, dehydration, sodium depletion, and to patients • Polyuria • Tremor • Diarrhea • Nausea • Hypothyroid • Teratogenic
<p>Lamotrigine</p> <p>Generic Available</p> <p>Lamictal®</p>	<p>Children: 2-5mg/day</p> <p>Adolescents: 25mg/day (increase by 25mg every 2 weeks)</p>	<p>Children:</p> <ul style="list-style-type: none"> • with Valproate 1-3mg/kg/day • with Valproate and EIAED's * 1-5mg/kg/day • Monotherapy 4.5-7.5mg/kg/day • with EIAED's 5-15mg/kg/day <p>Adolescents:</p>		<p>Approved for adjunctive therapy for Seizure Disorders in 2 years and older</p> <p>Maximum dose 500 mg/day</p> <p>Safety and effectiveness for treatment of Bipolar Disorder in patients below 18 years has not been established</p>	<p>Once to twice daily initially, then twice daily for maintenance</p>		<p>Serious rashes including Stevens-Johnson syndrome and aseptic meningitis</p>	<ul style="list-style-type: none"> • Dermatological reactions • Potential Stevens Johnson Syndrome • Acute-multi organ failure • Withdrawal seizures • Blood dyscrasias • Hypersensitivity

Drug	Starting Dose	Target Dose or Range	Literature Based Maximum Dosage	FDA Approved Maximum Dosage for Children and Adolescents	Schedule	Baseline Monitoring	Black Box Warning	Warnings and Precautions
		<ul style="list-style-type: none"> • with Valproate 100-200mg/day • with Valproate and EIAED's 100-400mg/day • Monotherapy 225-375mg/day • with EIAED's 300-500mg/day 						<p>y</p> <ul style="list-style-type: none"> • Suicidal ideation

* EIAED's - Enzyme Inducing Anti-Epileptic Drugs (e.g. Carbamazepine, Phenobarbital, Phenytoin, Primidone)

Glossary

BMI = Body Mass Index. A measure of body fat based upon height and weight.

CBC = Complete blood count. Lab test used to monitor for abnormalities in blood cells, e.g., for anemia.

Serum creatinine = A lab test used to calculate an estimate of kidney function.

ECG = Electrocardiogram

EPS = Extrapyrarnidal side effects. These are adverse effects upon movement, including stiffness, tremor, and severe muscle spasm

FDA = U.S. Food and Drug Administration

Hemoglobin A1c = A laboratory measurement of the amount of glucose in the hemoglobin of the red blood cells. Provides a measure of average glucose over several days.

LFTs = Live function tests

MAOIs = Monoamine Oxidase Inhibitors

Prolactin = A hormone produced by the pituitary gland.

TFTs = Thyroid Function Tests

Appendix B

**Comments on Psychotropic Medication Utilization Parameters for Foster Children
(December 2010 version).**

**Texas Department of Family and Protective Services &
University of Texas College of Pharmacy**

Review Provided by

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May, 2012

General Comments: This is a timely and informative document that provides helpful recommendations to guide the appropriate use of psychotropic medications for children in foster care. Because this population commonly presents with complex mental and general health needs and concern has been raised over the quality of their psychotropic medication management (1), a strong public health rationale exists for developing and implementing practice parameters in this area. Two particular strengths of the utilization parameters for prescribing physicians are the sections on Criteria Indicating Need for Further Review of Child's Clinical Status and the medication charts. We did not note evidence of bias or inappropriate clinical science in the document. However, we note several issues below that we suggest be considered for revision.

The document would be strengthened by additional information concerning evidence-based non-pharmacological treatments (Review: 2). Examples include multidimensional treatment foster care (3) and trauma-focused cognitive behavioral therapy (4), which has robust and enduring benefits, and therapeutic foster care, which reduces violence in persistently delinquent foster care youth (5). In addition, greater attention would be welcomed regarding monitoring the health and metabolic status of foster care youth who are receiving medications, especially the antipsychotic medications (6).

Introduction and General Principles

This introductory section succinctly captures specific diagnostic challenges in this population. However, these issues might be more effectively linked to treatment planning and to clinical decisions in managing medications. Appropriate mention is made of the frequent absence of birth family history, complex symptom presentations, and the challenges to establishing appropriate rapport. The recommendations of comprehensive evaluations including health histories and psychological testing are acknowledged. In this context, the discussion of the specific implications of these important clinical issues for treatment planning in this patient population would benefit from greater elaboration.

Parameters for Pharmacological Treatment

Greater attention might also be focused on the need for a careful risk/benefit evaluation and consideration of lower risk alternatives before considering psychotropic medication use. In general, we note three potential changes to the document: (1) increased emphasis might be placed on comprehensive psychosocial assessment and treatment planning, (2) consideration of *non-pharmacologic interventions* before psychotropic medications, and (3) *monitoring*.

Assessment and treatment planning: Although the focus of the parameters is on treatment with psychotropic medication, further emphasis might be given to clinical assessment. The reviewers thought this might warrant a separate section focused on assessment and treatment planning. Specifically, the parameters would be strengthened by highlighting the importance of reconstructing a developmental history in relation to trauma, neglect, and abuse that the child may have experienced. Clinical experience suggests that the impact of these stressors differs at different ages. Assessments might further include evaluation and targeting of non-traumatic stressors, triggers and ameliorating factors as well as efforts to identify and strengthen resilience factors within the youth and his or her environment. For example, inconsistent or abusive parenting is known to increase the risk of dysregulated cognitions and the management of anxiety and impulses (7). Over time these manifestations may qualify as diagnoses. An understanding of the etiology may influence clinical management. Major depressive disorder in a child without external stressors, for example, may have substantial contributing genetic factors, while "depression" in a foster child may stem from learned hopelessness and bereavement. Responses to antidepressant medications may in turn differ depending on the etiology of the symptoms. Greater attention might be given to these issues as well as strategies for managing disordered regulation of behavior. A role for consultants in supporting community providers and evidence-based psychosocial treatments might be acknowledged.

These children also often have a history of *in utero* drug or alcohol exposure and a family history of major psychiatric disorders or learning disabilities. Part of a good clinical assessment should include the child's ability to self-regulate and his or her cognitive and academic functioning.

The draft parameters also note the frequent lack of available of mental health history. Key information deficits often extend to medical and psychosocial history. As a result, the treating psychiatrist may not be able to share responsibility for medical care with a pediatrician, and must therefore devote more time to evaluating the child's general medical health, identifying concurrent or previous general illnesses. Without reliable historical information, the treating clinician may need to evaluate the child's trauma and self-regulation clinically, by closer observation of behavior and the relationship the child forms with him/her. This may be particularly true for pre-school children who likely comprise a substantial proportion of the Texas foster care population.

Psychosocial Interventions. As noted above, non-pharmacological interventions may need to address the child's need for stability and emotional infusion of acceptance, without which medications may not be effective. They also need to address the function that mal-adaptive behaviors may have played in a child's life in a previous setting that need to be specifically attended to in treatment. While assignment of a diagnosis is often necessary, a more specific focus on individual symptoms is often necessary to develop an effective treatment plan.

Many children who have experienced trauma do not meet strict diagnostic criteria for PTSD (8). Yet trauma may still influence the child's self-regulation including threshold for anxiety, coping skills, and response to stressors. The parameters might be strengthened by underscoring the importance of a trauma-informed, recovery-based approach to developing and implementing a treatment plan, of which medication treatment may be only one component. In fact, recent research suggests that the SSRIs are not effective in addressing PTSD in children (9).

Monitoring. We would recommend that monitoring guidelines be a stronger focus in general. Psychotropic medications include a number of classes of medications, including stimulants, antidepressants and anxiolytics, mood stabilizers and antipsychotics. Several of these classes of medications have serious metabolic implications. Specific metabolic monitoring guidelines should be added to the antipsychotic section. The monitoring guidelines should indicate the parameters to be measured, such as BMI, blood pressure, lipids, and fasting glucose, and the frequency of recommended measurements. Several organizations and professional societies have published recommended monitoring schedules that may be useful in developing practice parameters in this area, such as the ADA/APA guidelines. Monitoring recommendations for other classes of medications would also be helpful to the provider. Last, periodic review and potential discontinuation trial schedules following standard guidelines (e.g., 12 months for antidepressants) could be further delineated.

Non-pharmacological treatment

The parameters note that in view of the stress and change in environmental circumstances associated with being a foster child, psychotherapy should generally begin before initiation of a psychotropic medication. A further recommendation to consider is that the prescribing physician should maintain ongoing contact with the clinician providing psychosocial treatment. Prescribing physicians who have a greater understanding of what is occurring in the child's life have opportunities to view clinical symptoms as more than overly simplified medication responses. A common example is that escalation of symptoms may occur in the context of visits with biological parents.

In discussing non-pharmacological treatments, consider indicating that medications for the most part play an adjunctive role and support the effectiveness of non-pharmacological or psychosocial treatments, and that evidence-based psychosocial treatments should represent the foundation of managing the complexities of these children.

If medications are employed, the prescribing physician should assume responsibility for monitoring related health issues. This typically involves general medical and psychiatric assessments and communication with child's other providers and foster care family.

Role of primary care providers:

This section was well written. Citation might be made to the American Association of Pediatrics algorithms for recognizing and treating mental disorders in children (10). Another resource that may be helpful would be the soon to be published RTI International-University of North Carolina Evidence-based Practice Center (RTI-UNC EPC) "Comparative Effectiveness of Interventions for Children Exposed to Maltreatment," as part of the Agency for Healthcare Research and Quality's (AHRQ) Effective Health Care (EHC) Program.

Specific Suggested Edits for Consideration:

1. Consider moving the last paragraph on page 3 to the prescribing information.
2. On page 4, in the second column under general principles, consider adding procedures, dose, frequency, intensity and duration of treatment.
3. If possible, a stronger rationale might be provided for the selection of a threshold of 5 or more psychotropic medications. Consideration should be given to lowering the threshold to 4. Clarity should also be provided on the issue of whether to include side-effect medications, many of which have psychotropic properties, in the count.
4. The medication utilization parameters would be more helpful if they included not only initial and maximal doses, but some information on typical adequate doses and titration schedules. Providers would benefit from clarity regarding both monitoring strategies as well as timing of typical discontinuation schedules.
5. Given the recent accumulation of reassuring information concerning cardiovascular risks associated with central nervous system stimulants (11-14), the language discussing this issue might be tempered.

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Appendix C

Questionnaire for Informed Consent To Psychotropic Medications for Foster Children In Non-Emergency Situations for Child Protection Court of Central Texas

This form is to be used by the person designated in the Department's Medical Consenter Authorization Form, or the court's order, to provide informed consent to the prescribing of psychotropic medications to a foster child in a non-emergency situation.

IF YOU ARE THE DEPARTMENT'S REPRESENTATIVE, PLEASE BRING A COPY OF THIS QUESTIONNAIRE TO THE NEXT COURT HEARING.

Note 1: *Except in the event of an emergency, "Informed Consent" should be obtained from the appropriate person before beginning psychotropic medication.* This checklist will help you acquire the information necessary to make an informed decision whether to consent to the prescribing of psychotropic medication for a foster child.

BACKGROUND

(To be obtained from child's caregiver and or caseworker)

Name of Foster Child: _____

Date the child was first placed in the current placement: _____

What is the Child's current weight in pounds? _____ (Necessary to determine some dosages where weight is a factor)

Child's Date of Birth: _____ (Necessary to classify child as a "child" 1-12 yrs, or an "adolescent" 13-18 yrs)

Date Information Obtained: _____ Prescriber's Name: _____

Signature of Person Filling Out This Questionnaire: _____

Printed Name of Person Filling Out This Questionnaire: _____

FOR EACH PSYCHOTROPIC MEDICATION TO BE PRESCRIBED OR EACH REQUESTED DOSAGE INCREASE, ASK:

Non-Psychotropic Medication Interventions:

What non-psycho pharmacological interventions were tried before turning to treatment with psychotropic medications:

For how long? _____

Questions for Prescriber:

Diagnosis: What is the DSM-IV (or current edition) psychiatric diagnosis for which the medicine will be prescribed?

_____.

What are the target symptoms for which the medication is to be prescribed:

Is the child currently on any other psychotropic medication for the treatment of these specific target symptoms? _____.

If yes, what is the generic/trade name of the medication & current total daily dosage: _____.

Prior to the initiation of any new medication, or a change in dosage of an already prescribed medication, ASK:

What is the name of the medication (generic & trade names) to be prescribed: _____

What classification is this medication? (anti-depressant, mood stabilizer, antipsychotic, stimulant, etc.): _____

NOTE: If the prescriber seeks to prescribe an anti-depressant for a child, how will the child be monitored for suicidality?

NOTE: If the medication to be prescribed is an ADHD Stimulant Medication:

_____ Did the clinician conduct a careful history of the child and family regarding potential heart problems?

_____ Has a thorough physical exam been conducted?

NOTE: If the history and physical exam provide suspicion of a cardiac problem, request an electrocardiogram before beginning a stimulant. If a child has a known history of a cardiac problem, request a cardiac consult before beginning a stimulant.

FOR THE MEDICATION TO BE PRESCRIBED, OR THE DOSAGE TO BE INCREASED, ask:

Is the medication FDA approved for use in children? _____; For use in adolescents? _____

What is the maximum recommended daily dosage for a child? _____; for an adolescent? _____

What total daily dosage does the prescriber want to prescribe? _____.

If this is not a minimum recommended dosage, or is a dosage increase, why is the prescriber recommending this total daily dosage? _____.

What are the risks associated with the medication the clinician wants to prescribe? _____

What are common side effects? _____

What are uncommon but potentially adverse events? _____

What are the expected benefits? _____

Is there a medication with lower risks for side effects or adverse events that is an alternative? _____

Why use this medication and not an available alternative medication, if any? _____

What is the overall benefit to risk ratio of treatment with this particular medication? _____

What are the risks if this medication is not prescribed? _____

The information below may be provided by whoever has the information (the caregiver, prescriber, or caseworker):
 FOR all other psychotropic medications that the child/adolescent is currently prescribed, list the following:

Generic & Trade Name of Psychotropic Medication	*Class/type Medication	DSM IV Diagnosis Medication is Treating	Symptoms Medication is Targeting	Total daily Dosage		Does	Current Dose (include # of times taken each day)

*Please see attached Psychotropic Medication Utilization Parameters (PMUP) for the class or type of medication if the prescriber did not provide this information.

*DOSAGE ABBREVIATIONS: PRN= pill as needed

If a child/adolescent is prescribed a medication "PRN" (as needed): what is the total daily amount taken each day?

INSTRUCTIONS TO THE PSYCHOTROPIC MEDICATION CONSENTER

UNLESS IT IS AN EMERGENCY OR AN URGENT SITUATION:

****If you are asked to consent to any of the situations described in this box, AND it is not an emergency or urgent situation, request a hearing to present the prescriber's justifications why it is medically necessary to exceed these guidelines. Until you have done so:***

_____ Do not consent to the addition or change of more than one psychotropic medication at a time.*

NOTE: Starting a new medication and beginning the dose tapering of a current medication is considered one medication change.

_____ Do not consent to two or more antidepressant medications at a time.*

_____ Do not consent to two or more antipsychotic medications at a time.*

_____ Do not consent two or more stimulant medications at a time.*

_____ Do not consent to two or more medications for the same DSM-IV diagnosis at a time.*

_____ Do not consent to more than 3 psychotropic medications of any kind at the same time.*

_____ Do not consent to prescribing antidepressant medication if a child is less than 4 years old.*

_____ Do not consent to prescribing antipsychotic medication if a child is less than 10 years old.*

_____ Do not consent to prescribing a psycho-stimulant medication if a child is less than 3 years old.*

_____ Do not consent to a dosage that exceeds the psychotropic medication utilization parameters

* If such information is not in the PMUP, do not consent to a dosage that exceeds the FDA approved maximum dosage for a child/adolescent (ask the prescriber what the FDA approved maximum dosage is for a child/adolescent). If the medication is not FDA approved for use with a child/adolescent, then ask what is the FDA approved maximum dosage for an adult).

Appendix D

Psychotropic Medications and Texas Foster Care Round Table

July 6, 2012

Participant List

NAME	TITLE/ORGANIZATION
Judge Scott McCown	Executive Director, Center for Public Policy Priorities
Judge John Specia	Jurist in Residence, Children's Commission
Judge Diane Guariglia	Co-Chair, Psychotropic Medications Workgroup, Associate Judge, 245 th Family Court
James Rogers, M.D.	Co-Chair, Psychotropic Medications Workgroup, Medical Director, Texas Dept. of Family & Protective Services, Adult & Child Psychiatrist
Tina Amberboy, J.D.	Executive Director, Children's Commission
Tiffany Roper, J.D.	Assistant Director, Children's Commission
Kristi Taylor, J.D.	Staff Attorney, Children's Commission
Milbrey Raney, J.D.	Staff Attorney, Children's Commission
Teri Moran	Communications Manager, Children's Commission
Mari Aaron	Executive Assistant, Children's Commission
Ron Clark	Business Analyst, Office of Court Administration
Stephen Crystal, PhD.	Associate Director for Health Services Research Institute for Health, Health Care Policy and Aging Research, Rutgers University
Sheree Neese-Todd, M.A.	Senior Research Project Manager, Institute for Health, Health Care Policy and Aging Research, Rutgers University
C. Mark Chassay, M.D.	Deputy Commissioner for Health Policy & Clinical Services, HHSC
Howard Baldwin, J.D	Commissioner, Texas Dept. of Family & Protective Services
Audrey Deckinga, M.S.S.W.	CPS Assistant Commissioner, Texas Dept. of Family & Protective Services

Liz Kromrei, L.C.S.W.	CPS Project Director, Texas Dept. of Family & Protective Services
Kathy Teutsch, R.N., L.M.S.W.-M.S.S.W.	Division Administrator for Medical Services, Texas Dept. of Family & Protective Services
Jane Burstain, PhD., J.D.	Sr. Policy Analyst, Texas Dept. of Family & Protective Services
Denise Brady, J.D.	Sr. Policy Attorney, Texas Dept. of Family & Protective Services
De Shaun Ealoms	Parent Program Specialist, Texas Dept. of Family & Protective Services
Courtney Jones	Youth Specialist, Texas Dept. of Family & Protective Services
Judge John Delaney	Senior District Judge, Child Protection Court
Judge Rich Garcia	Associate Judge, Bexar County Children's Court
Judge John Hathaway	Associate Judge, Travis County Juvenile Court
Judge Bonnie Hellums	Judge, 247 th District Court
Judge Jo Ann Ottis	Judge, Child Protection Court
Judge Ron Pope	Judge, 328 th District Court
Judge Denise Pratt	Judge, 311 th District Court
Judge Suzanne Radcliffe	Associate Judge, 306 th District Court
Judge Robin Sage	Judge, CPC Northeastern Texas Foster Care Docket
Connie Almeida, Ph.D.	Director, Behavioral Health Service, Ft. Bend Co.
Katherine Barillas, PhD.	Policy Fellow, One Voice Texas
Cathy Cockerham	Program Operations Director, Texas CASA
Tushar Desai, M.D.	Adolescent & Pediatric Psychiatrist
Tracy Eilers, D.M.	Director, Foster Care, Cenpatico
Benigno Fernandez, M.D.	Medical Director, Laurel Ridge Hospital
David Harmon, M.D.	Chief Medical Officer, STAR Health
Robert L. Hartman, M.S.W.	Executive V.P. & COO, DePelchin Children's Center
Ebony Jackson	Child Advocacy Specialist, CASA of Travis County
Yvette Jircik, J.D.	Assistant County Attorney, Harris County

David Kemp	Board Member, CASA – Kingsland
Mark Konyecsni, M.D.	Medical Director, Cenpatico
Katharine Ligon	Center for Public Policy Priorities
Diana Martinez	Director of Public Policy and Education, TexProtects, The Texas Association for the Protection of Children
Eric McFerren, J.D.	Attorney Ad Litem, Harris County
Beth Mitchell, J.D.	Disability Rights Texas
Nina Jo Muse, M.D.	Psychiatric Advisor, Dept. of Health & Social Services
Sandeep Narang, M.D., J.D.	Asst. Prof. of Pediatrics, UT Health Sciences Center at San Antonio
Cynthia O’Keeffe, J.D.	Deputy Chief, Civil Medicaid Fraud Division, Office of the Attorney General
Steve Pliszka, M.D.	Chief of Child Psychiatry, UT Health Services at San Antonio
Asif Siddiqui, M.D.	Child, Adolescent and Adult Psychiatrist, Providence Service Corporation
Vicki Spriggs, M.A.	CEO, Texas CASA
Jeannie Von Stultz, PhD.	Director of Mental Health Services, Bexar County Juvenile Probation
Claire Wiley	Legislative Aide, Representative Mark Strama
Bobbie Young, J.D.	Attorney Ad Litem, Harris County