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Psychotropic medications in child welfare: From federal mandate to direct care☆

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ABSTRACT

Background and objective: Children in the welfare system are prone to uncoordinated and unmonitored mental health care, including psychotropic medications. To address these issues, federal legislation mandated that state child welfare agencies improve the coordination and oversight of psychotropic medications. However, there is no clear guidance on how to improve these practices, particularly at the level of direct care. We aimed to identify specific areas for improvement through state-wide surveys of four groups.
Methods: We surveyed all known members of four groups working directly with children in foster care in one small northeastern state. Respondents included 209 foster and adoptive parents, 169 child welfare staff, 84 mental health therapists, and 33 clinical prescribers. Survey items addressed practices and perceptions related to sharing of information and cross-system communication and monitoring of medication effects and side effects.
Results: Nearly two in five foster and adoptive parents reported *not* regularly receiving information about the purpose or side effects of psychotropic medications, and they disagreed among themselves on who was primarily responsible for monitoring safety and effectiveness. One-third of child welfare staff and two-thirds of mental health therapists reported that information about psychotropic medications is *not* regularly shared with the child's provider team. Half of clinical prescribers reported *not* regularly communicating with child welfare staff.
Conclusions: We identified specific areas for improvement related to communication, sharing of information, monitoring, and role clarification. Strategies to improving these activities are key to ensuring the safe and effective use of psychotropic medications in this population.

1. Introduction

Recent US national studies report rates of psychotropic medications for children in foster care between 13 and 40% (Leslie, Raghavan, Zhang, & Aarons, 2010; Raghavan & McMillen, 2008; Raghavan et al., 2005). These rates are 2 to 4.5 times higher than that of all children enrolled in Medicaid (Kutz, 2011; Raghavan, Brown, Allaire, Garfield, & Ross, 2014). Higher psychotropic medication use, if safe and effective, may not be problematic, particularly given the elevated clinical needs in this population (Simms, Dubowitz, & Szilagyi, 2000; Stahmer et al., 2005). However, studies have shown that psychotropic medications for children in foster care vary by factors other than clinical need – such as geography, gender, race and ethnicity - suggesting unwarranted variation (Leslie et al., 2011; Raghavan, Brown, Allaire, Garfield, Ross, et al., 2014). In addition, the high rates of polypharmacy, doses exceeding the maximum recommendation for the child's age, and use of these medications in very young children are problematic in nearly all circumstances (Kutz, 2011). It is important to note that certain sub-populations of children in foster care may also be under-prescribed medications for mental health conditions (Raghavan & McMillen, 2008), although the majority of research findings suggest a potential over-use.

A number of hypotheses have been put forth to explain the potential over-use of psychotropic medications in this population. First, there is inadequate mental health care for children in child welfare on a broader level, including a lack of access to evidence-based psychosocial interventions and expert child psychiatrists (Burns et al., 2004). Changing homes and providers leads to discontinuity in care. Discontinuity creates gaps in medical and background information and poses challenges to communication across providers and caregivers (Stahmer et al., 2005), potentially culminating into a vacuum in treatment oversight

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(Camp, 2011). There is also no conclusive research base or practice parameter for the pharmacological care of children who have experienced trauma and traumatic stress symptoms, leaving clinicians with little guidance to care for these children. Additional hypotheses regarding risky prescription practices for children in foster care include pressures from foster parents and school staff to manage children's behaviors quickly, and time pressures placed on prescribers during sessions to make treatment recommendations (Alavi & Calleja, 2012; Camp, 2011; Harrison, Cluxton-Keller, & Gross, 2012). Research also suggests that foster parents, foster youth, and other vulnerable children in restrictive settings (i.e. residential facilities, hospitals) feel disempowered in psychiatric care decisions (Leslie, Dawson, et al., 2010; Leslie, Raghavan, et al., 2010; Moses, 2011; Murphy et al., 2015), perhaps shedding light on the issue. For example, in a sample of 50 high-risk adolescents taking psychotropic medications, 44% perceived being forced to take psychotropic medications, and 62% would discontinue the medication if they did not perceive outside pressures (Moses, 2011).

1.1. Legislative and regulatory reforms

To address the problems identified in the health care of children in foster care, two laws have amended Section 422(b)(15) of the Social Security Act 42 U.S.C. 622(b)(15). These laws require state child welfare agencies, in collaboration with others, to develop a "plan for ongoing *oversight* and *coordination* of health care services," including psychotropic medications, for any child in a foster care placement. The legislation included six parts to be included in the plan: (i) a schedule of health screenings, (ii) how health needs will be monitored and treated, (iii) how medical information will be updated and shared, (iv) steps to ensure continuity of health care services, (v) the oversight of prescription medicines, and (vi) how the State will actively consult with and involve physicians or other appropriate medical or non-medical professionals. Oversight and coordination of psychotropic medications are clearly multidimensional across a number of sequential activities, beginning at the time of initial referral to mental health, and continuing through a child's maintenance on psychotropic medications.

Numerous government, health care, academic, advocacy, and state child welfare agencies have issued recommendations and practices to address the potential over-use of psychotropic medications in this population. For example, the US DHHS Administration for Children Youth and Families issued an Information Memorandum in 2012 (ACYF-CB-IM-12-03) (US Department of Health and Human Services, 2012), the National Alliance on Mental Illness (2011) and the Government Accountability Office (Kutz, 2011) both released statements to the senate in 2011, and the American Academy of Child and Adolescent Psychiatrists released position statements and practice guidelines in (American Academy of Child and Adolescent Psychiatry, 2005) and (American Academy of Child and Adolescent Psychiatry, 2015).

Common recommendations have largely focused on higher-level oversight, as opposed to direct care, and include activities such as developing and disseminating best practice guidelines for prescribers providing care to children in foster care, building databases to monitor medications in real time, and installing pre- or post-authorization requirements (Naylor et al., 2007; Noonan & Miller, 2013) targeting more safe prescriptions. Nearly all states have a child welfare policy in place or in development (Noonan & Miller, 2013). However, these policies have been criticized for being underdeveloped (e.g., do not include red flag prescription guidelines), non-transparent (i.e. unavailable) to stakeholders and the public for comment, and for lacking formalization through legislation and other mechanisms to ensure recourse and accountability (Noonan & Miller, 2013). Despite efforts and recommendations by professionals and mental health advocacy groups, it is clear that most states have not fully implemented the federal mandate, particularly at the level of direct care.

1.2. Our state

In 2012, 511 (34.5%) of the 1481 children in placement (e.g., foster care, residential care) within our state's child welfare system were prescribed at least one psychotropic medication. Ninety-eight (19%) children were prescribed three or more psychoactive medication. Twelve of 511 (2%) of these children were age 7 or below. Fifty-three (11%) were prescribed two or more medications within the same medication class. Of the psychotropic medications prescribed, 41% were antidepressants, 23% antipsychotics, 21% "ADHD medications", 8% antianxiety medications, and 7% mood stabilizers.

In 2012, leaders from an academic institution and the state child welfare system joined together as part of a federally-funded, 5-year system change project associated with this study. One goal of this partnership was to improve the safe and effective use of psychotropic medications in the state's child welfare population. We formed a multi-disciplinary group to guide policy and practice changes around these issues. We put into place a child welfare policy guideline for prescribing clinicians and stakeholders (e.g., payor officials) that included, among other things, specific "red flag" criteria (e.g., four or more psychotropic medications) and monitoring protocols delineated by practice guidelines. We created a webpage within the state's website that includes the policy as well as multiple resources for prescribing clinicians, youth, caregivers, and other professionals related to best practice psychotropic and psychosocial treatments and youth and caregiver engagement. We implemented a new informed consent process as well as a tracking and review protocol for psychotropic medications prescribed to children in the state's legal guardianship. We are currently collaborating with our state's Managed Care Organizations and Medicaid to eventually use real-time claims data to review medications and monitoring protocols and explore other oversight opportunities. We are also considering several direct-care strategies to improve stakeholder education, engagement, and advocacy toward the safe and effective use of psychotropic medications.

1.3. Purpose of the current study

The purpose of the current study was to identify specific areas for practice improvement related to coordination and oversight at the level of direct care by surveying perceptions and practices of multiple caregiver and provider groups involved with the state's child welfare system. An examination of the process of psychotropic medication prescription and use shows the central role of four groups. Children are assessed and monitored by *child welfare staff* as to current psychological needs. They are re-assessed, if informally, by *foster parents*, who are responsible for administering the medication. If either of these stakeholders become concerned, referral to a *mental health therapist* (who can refer to a clinical prescriber), or directly to a *prescriber*, can occur. Parents, child welfare staff, and therapists can communicate directly with prescribers on an ongoing basis, which could result in medication changes.

An assessment of current perceptions and practices is necessary before leaders and policy makers can develop specific strategies that will be effective in practice and meet federal mandates. More specifically, findings can assist leaders in identifying the most strategic areas for practice improvement and policy development, such as clear definitions of stakeholder roles and responsibilities, and the need for information-sharing systems. This study also informed the goals and activities of our state-wide SafeRx committee and larger federal project. Follow-up surveys at the end of our project will be compared to the current findings to evaluate any changes in perceptions and practices following the implementation of project activities. To our knowledge, this is the first study to quantitatively evaluate and triangulate these constructs across multiple stakeholder groups.