California Policy: Ensuring that Youth in Out of Home Care are only Prescribed Psychotropic Medication when it is in their Best Interests.

Executive Summary: California has developed policy related to data collection to monitor the administration of psychotropic medications to youth in foster care. It also has fairly comprehensive guidelines on best practices in prescribing. It has far less policy, however, requiring or enforcing these best practices. Informed assent by youth is also not required by statute.

Psychotropic Medication Definition: Psychotropic medications are defined by California statute[1] as "Medications prescribed to affect the central nervous system to treat psychiatric disorders or illnesses. They may include, but are not limited to, anxiolytic agents, antidepressants, mood stabilizers, antipsychotic medications, anti-Parkinson agents, hypnotics, medications for dementia, and psychostimulants."

Policy Advisory Board: The State of California established a Quality Improvement (QI) Project to develop the standards for safe and appropriate prescribing and monitoring of psychotropic medications for foster children as required by the federal Child and Family Services Improvement and Innovation Act (2011). The QI Project is a collaborative effort between the Department of Health Care Services (DHCS) and the California Department of Social Services (CDSS). The group created a set of guidelines and accompanying appendices entitled California Guidelines for Psychotropic Medication Use with Children and Youth in Foster Care (henceforth "Guidelines") that are updated annually. The guidelines are statements of best practice for the treatment of youth in out of home care with psychotropic medications, and lay out basic principles, values, and expectations in developing treatment plans.[2]

Prohibitions: The guidelines state, "Psychotropic medications should not be used for the purpose of discipline or chemical restraint, except as acutely necessary in true psychiatric emergencies (Title 22, CCR, Section 22 51056). Youth are not to be coerced into taking medication as a condition of placement."[3]

CDSS's Foster Youth Mental Health Bill of Rights states, "All foster youth have a right to be free from physical, sexual, emotional, or other abuse, or corporal punishment. Cal. Welf. & Inst. Code § 16001.9(a)(2). Foster care providers should respect a foster youth's right to refuse to take psychotropic medications and avoid practices or policies that punish or penalize a youth for exercising this right."[4]

Prescribing Standards for ages 0-5 only allow prescriptions for stimulants, atomoxetine, guanfacine, clonidine, or risperidone (for Autistic Spectrum Disorders and associated aggression).[5]

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[1] Cal. Welf. & Inst. Code § 369.5(d)

[2] CDSS Quality Improvement Project http://www.cdss.ca.gov/inforesources/Foster-Care/Quality-Improvement-Project; DHCS Quality Improvement Project https://www.dhcs.ca.gov/provgovpart/pharmacy/Pages/QIPFCP/QIPmain.aspx

[3] California Guidelines for Psychotropic Medication Use with Children and Youth in Foster Care at 6, https://calswec.berkeley.edu/sites/default/files/ca_guidelines_1.pdf.

[4] Foster Youth Mental Health Bill of Rights fn 24, http://www.childsworld.ca.gov/res/pdf/QIP/FosterYouthMentalHealthBillOfRights.pdf.

[5] Foster Care Quality Improvement Project Appendix A: Prescribing Standards of Psychotropic Medication Use by Age Group, https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/QIP_Appendix_A_18.pdf.

Polypharmacy: The Guidelines lay out in Appendix A the number of psychotropic drugs by class and in total that can be prescribed in different age groups. The guidelines allow the following:
Total number of psychotropic medications for youth ages (in years):

12-17	<4 psychotropic medications
6-11	<3 psychotropic medications
0-5	<2 psychotropic medications

Number of psychotropic medications by class for youth:
Ages 12-17
a. <2 antipsychotics (any combination of atypical and typical)
b. <2 mood stabilizers (anti-psychotics not included)
c. <2 antidepressants (trazodone as hypnotic excepted)
d. <2 stimulants (this does not include a long-activating stimulant and immediate-release stimulant that is the same chemical entity (e.g.; methylphenidate-OROS and methylphenidate)
e. <2 hypnotics (including trazodone, diphenhydramine, zolpidem and melatonin, benzodiazepines, not including clonidine, guanfacine, and prazosin)
f. Medication dose(s) within the usual recommended dose(s) as defined in the most recent version of the State parameters (adaptation of the Los Angeles County Department of Mental Health's Parameters 3.8 For Use of Psychotropic Medication For Children and Adolescents (Reference 2))

Ages 6-11
a. All other restrictions from above.

Ages 0-5
a. All other restrictions from above.
b. Allows stimulant, atomoxetine, guanfacine, clonidine, or risperidone (for Autistic Spectrum Disorders and associated aggression) only.[6]

Dosages: Appendix B of the Guidelines adopt the Los Angeles County Department of Mental Health (LACDMH) Parameters 3.8 for Use of Psychotropic Medication for Children and Adolescents. The parameters "represent[] a consensus of best practices from among various experts from Los Angeles training institutions and experienced community based clinicians who provide treatment to children and adolescents," and "are updated quarterly to reflect improvements in evidence based treatments."[7] The parameters lay out best practice dose ranges and dosage schedules, although they are not calibrated to children "whose ability to metabolize and excrete these drugs may be compromised."[8] It states, "Treatment provided outside of the parametric elements in this guide requires special justification and/or consultation and subsequent relevant documentation of the rationale."[9]

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[6] Foster Care Quality Improvement Project Appendix A: Prescribing Standards of Psychotropic Medication Use by Age Group, https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/QIP_Appendix_A_18.pdf.
[7] Appendix B: DMH Parameters 3.8 For Use of Psychotropic Medication for Children and Adolescents https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/QIP_Appendix_B_18.pdf.
[8] Parameters 3.8 for Use of Psychotropic Medication for Children and Adolescents, http://file.lacounty.gov/SDSInter/dmh/1052108_PSYCHOTROPICPARAMETERS-12-19-18-POST.pdf.
[9] *Id.*

Off-label Uses: The Guidelines Appendix C provides that "Any off-label use of medication should have some evidence available to support its use published in peer reviewed literature…. In addition, deviations from general practice guidelines should be adequately supported/ justified."[10]

Prior Authorizations: DHCS requires physicians to complete a treatment authorization request (TAR) form prior to prescribing antipsychotic medications to youth 17 and younger covered by Medi-Cal.[11] (This TAR is not required for other classes of psychotropic medications besides antipsychotics.) The dispensing pharmacy must submit the TAR, and a state pharmacist reviews and verifies the medical necessity of the prescription before payment under Medi-Cal can be authorized.

Informed Consent and Assent: California Code WIC §§ 369.5 and 739.5 provide that "only a juvenile court judicial officer shall have authority to make orders regarding the administration of psychotropic medications" for a youth in foster care.[12] (The court may issue an order delegating this authority to a parent upon making certain findings.) Court authorization for the administration of psychotropic medication is initiated by and based on a request from a physician, submitted to the court using Judicial Council forms created pursuant to California Rules of Court, Rule 5.640, which specifies the procedures for obtaining and documenting judicial authorization.[13] This is often referred to as the "JV-220 process," as JV-220 is the main required form. Form JV-217-INFO provides guidance on the required and optional psychotropic medication court forms.[14] The JV-220 request must include the reasons for the request, a description of the child's diagnosis and behavior, the expected results of the medication, and a description of any side effects of the medication.

California law does not require informed consent or assent from the youth being prescribed medication. The Guidelines' principles state, "Respect for the independence and autonomy of the child and family is implicit in the requirement for informed consent and assent. Children are included in the consent and assent process to the extent feasible and appropriate based on their developmental stage."[15] The prescriber should describe the proposed treatment in terms understandable to the child and family, including the risks and benefits of the proposed treatment and of alternative treatments, so that they can make an informed choice about whether to consent and assent to medication. The doctor must tell the judge in JV-220 whether the youth agrees or disagrees with the doctor's recommendation.[16] One of the optional forms, JV-218, provides an (but not the only) opportunity for the youth to tell the judge what they think about the medication.[17] Optional forms JV-219 and JV-222 allow other interested persons (parent, guardian, caretaker, CASA, GAL, Tribe, etc.) an opportunity to give their opinion to the judge in writing.[18]

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[10] Appendix C: Challenges in Diagnosis and Prescribing of Psychotropic Medications.
[11] Supplement for Antipsychotic Treatment Authorization Request (TAR) for Ages 17 Years and Younger, https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/QIP_APTARSupp.pdf.
[12] Cal. Welf. & Inst. Code §§ 369.5, 739.5.
[13] JV-220 Application for Psychotropic Medication et seq.
[14] JV-217-INFO Guide to Psychotropic Medication Forms, https://www.courts.ca.gov/documents/jv217info.pdf.
[15] Guidelines sec G, p 11.
[16] Cal. R. of Ct. 5.640(c)(6)(G); Cal. Juv. Ct. Form JV-220(A)(1)(a).
[17] JV-218 Child's Opinion About the Medicine, https://www.courts.ca.gov/documents/jv218.pdf.
[18] Form JV-219 Statement About Medicine Prescribed, https://www.courts.ca.gov/documents/jv219.pdf; Form JV-222 Input on Application for Psychotropic Medication, https://www.courts.ca.gov/documents/jv222.pdf.

The Foster Youth Mental Health Care Bill of Rights states, "Foster youth are able to participate in decisions made about whether to prescribe psychotropic medication. Whenever possible and appropriate, a foster youth's expressed preferences are followed, including his or her desire to not take psychotropic medication."[19] It also states, "Foster youth are not penalized or punished for refusing to take psychotropic medications."[20] It cites the American Medical Association Code of Medical Ethics and a guide published by the American Academy of Child and Adolescent Psychiatry in noting that "Medical ethics generally require that doctors get assent… from older youth (typically twelve or older) before prescribing psychotropic medication except in emergency situations . . . ."[21]

Exceptions to Consent: A doctor may only administer psychotropic medication without a court order on an emergency basis. For a situation to qualify as an emergency, the doctor "must find that the child's mental condition requires immediate medication to protect him/her or others from serious harm or significant suffering, and that waiting for the court's authorization would put the child or others at risk."[22] The doctor then has at most two days to ask for the court's authorization.

Consultation/Secondary Review: The Prescribing Algorithm (Decision Tree) in Appendix D notes in Section B that "the decision to treat a child with more than one medication from the same class" or "a clinician prescribing more than 3 psychotropic medications to one child … may warrant a second review by a Child and Adolescent Psychiatrist."[23]

The California Legislature passed Senate Bill No. 89 in 2017,[24] requiring CDSS, in consultation with DHCS, to contract for child psychiatry services to complete record reviews for specified authorization requests for psychotropic medications for which a second opinion review is requested by a county. The bill also required DSS to issue guidance regarding the second opinion review process by July 1, 2018. The bill is incorporated into Sections 369.6 and 739.6 of the Welfare and Institutions Code.

Enforcement: Senate Bill No. 1174,[25] passed in 2016, requires CDHS and CDSS to share data with the California Medical Board regarding Medi-Cal physicians and their prescribing of psychotropic medication. The purpose of sharing this data is for the Medical Board to review the data identify any illegal practices or patterns of overprescribing psychotropic medications to youth in foster care. The bill requires the Medical Board to review the data and take appropriate action

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[19] Foster Youth Mental Health Bill of Rights at 3, http://www.childsworld.ca.gov/res/pdf/QIP/FosterYouthMentalHealthBillOfRights.pdf.

[20] *Id.*

[21] *Id.* at 5 fn 2 (*citing* American Medical Association Code of Medical Ethics, Opinion 10.016 ("Physicians should give pediatric patients the opportunity to participate in decision making at a developmentally appropriate level. The physician should seek the patient's assent, or agreement, by explaining the medical condition, its clinical implications, and the treatment plan in ways that take into account the child's cognitive and emotional maturity and social circumstances.")); at 6 fn 9; at 8 fn 22 (*citing* Am. Acad. of Child & Adolescent Psychiatry, A Guide for Public Serving Agencies on Psychotropic Medications for Children and Adolescents 8-9 (Feb. 2012)).

[22] JV-217-INFO Guide to Psychotropic Medication Forms at 1, https://www.courts.ca.gov/documents/jv217info.pdf.

[23] Appendix D Algorith (Decision Tree) for the Prescribing of Psychotropic Medications at 4.

[24] SB 89, https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180SB89

[25] SB 1174, https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB1174

if they find violations. The bill is incorporated in Section 2245 of the Business and Professions Code and Section 14028 of the Welfare and Institutions Code.

Data Reporting: The California Legislature has passed a number of bills requiring data sharing among agencies, specifying what data is to be collected by whom, and how frequently it must be reported.[26]

Senate Bill No. 238[27] was passed in 2015 and requires data sharing between state and county agencies as well as county-specific monthly reports from CDSS. Implementation of this bill is still in process. The bill is incorporated in Section 16501.4 of the Welfare and Institutions Code.

Senate Bill No. 484,[28] also passed in 2015, requires data collection regarding the administration of psychotropic medications to youth in group homes. The bill is incorporated in Section 1538.8 of the Health and Safety Code.

Senate Bill No. 1291,[29] passed in 2016, requires DHCS to share data about Medi-Cal eligible youth in foster care for annual reviews of mental health plans by an external quality review organization. The bill is incorporated in Section 14717.5 of the Welfare and Institutions Code.

Public Health Nurses: Senate Bill No. 238[30] also required CDSS to establish a program of public health nurses to work with the appropriate child welfare services workers to coordinate health care services and serve as a liaison with health care professionals and other providers of health-related services for youth in foster care. The bill is incorporated in Section 16501.3 of the Welfare and Institutions Code.

[26] *See e.g.*, SB 238, SB 484, SB 1174, SB 1291.
[27] SB 238, https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB238
[28] SB 484, https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB484
[29] SB 1291, https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB1291
[30] SB 238, https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB238

New Mexico Policy: Ensuring that Youth in Out of Home Care are Only Prescribed Psychotropic Medication when it is in their Best Interests.

Executive Summary: Section 6A of New Mexico Chapter 32A, known as The Children's Code, contains provisions regulating children's mental health services.[31] The statute provides some safeguards related to psychotropic mediation, but its application is to all children, not children in the custody of New Mexico's child welfare agency, known as **Children, Youth and Families Department (CYFD). Over** at least the past thirteen years in New Mexico, leadership efforts were made to increase monitoring and oversight of psychotropic medication prescription and administration among children and youth in foster care in New Mexico.[32,33] Eventually, these efforts stalled. As such, no substantive regulation related to psychotropic medication prescription to children in out of home custody exists today.[34,35]

Definition: The New Mexico Professional Psychologist Act defines psychotropic medication as "a controlled substance or dangerous drug that may not be dispensed or administered without a prescription and whose primary indication for use has been approved by the federal food and drug administration for the treatment of mental disorders and is listed as a psychotherapeutic agent in drug facts and comparisons or in the American hospital formulary service."[36]

Consent: In New Mexico, psychotropic medications may be administered to a child (regardless of custody status) with proper consent. For a child under the age of fourteen, informed consent must be obtained from the child's parent, guardian or legal custodian. [37] When applicable to children in residential treatment, the child's guardian ad litem shall be notified by the residential treatment program of psychotropic medication administration. Youth age 14 and older must

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[31] N.M.Stat.§32A, Children's Code (1978). https://laws.nmonesource.com/w/nmos/Chapter-32A-NMSA-1978#!fragment/zoupio-_Toc12630951/BQCwhgziBcwMYgK4DsDWszIQewE4BUBTADwBdoAvbRABwEtsBaAfX2zgEYAmANgGYADAE4ArBwCUAGmTZShCAEVEhXAE9oAcg2SIcXNgA2BgMJI00AITIdhMLgRKV6rTbsIAynlIAhdQCUAUQAZAIA1AEEAOWMAyVIwACNoUnZxcSA

[32] See CYFD, Protective Services Division, New Mexico 2011 – 2012 Annual Progress & Services Report, "New Mexico's protocol for the oversight of psychotropic medication is currently being developed on three levels: Case/Individual Level; PSD Systems Level; and Oversight." p.71. https://cyfd.org/docs/2011-12_APSR_063012.pdf

[33] *See* Amy Linn, Searchlight New Mexico: Prescription for disaster: Lax oversight puts New Mexico kids in danger. *Santa Fe New Mexican* (October 18, 2018). https://www.santafenewmexican.com/news/local_news/prescription-for-disaster-lax-oversight-puts-new-mexico-kids-in/article_7a1a6b0e-d96b-5788-8dfe-d1285a4414c1.html. "Davis says he first started working on 'best practice' guidelines for youth in 2006, but 'I couldn't get CYFD or HSD to publish them.' Between 2013 and 2017, he met with a task force to hammer out a comprehensive set of guidelines intended to 'red flag' doctors who prescribed excessive amounts of psychiatric drugs to children. That, too, disappeared down a bureaucratic hole."

[34] *Id.*

[35] Amy Linn, Searchlight New Mexico: Warrant: Albuquerque psychiatrist over-medicated hundreds of children in his care. *Carlsbad Current Argus* (Oct. 30, 2018). https://eu.currentargus.com/story/news/local/2018/10/30/psychiatrist-drug-overdose-deaths-albuquerque-new-mexico/1812010002/

[36] N.M.Stat.§61-9-3 (F). Professional Psychologist Act, Definitions (2018). http://www.rld.state.nm.us/uploads/files/Psychologist%20Examiners%20Rules%20and%20Statutes%20-%20Effective%20July%201%2C%202018%20(Printable%202%20Sided).pdf

[37] N.M.Stat.§32A-6A-14 (A)-(C), Children's Mental Health and Developmental Disabilities (2007). https://laws.nmonesource.com/w/nmos/Chapter-32A-NMSA-1978 N.M. Stat. § #!b/32A-6A-14.

consent to treatment with psychotropic medication, while their parents are entitled to receive notice.[38]

Exception to Consent: A licensed physician can administer psychotropic medication on an emergency basis absent consent from a youth over 14 who may lack capacity to consent. The procedure requires a court hearing to determine whether the appointment of a treatment guardian is appropriate. Following appointment, the treatment guardian can provide consent, but must also take into account the expressed opinion of the child. Following administration, the prescribing physician must write a report in the case record that explains the emergency circumstances and the rationale for prescription. Procedures for forced medication administration are also identified.[39]

Children in Out-of-Home Treatment: Statute provides that medication cannot be used to discipline children in out of home treatment, for staff convenience, or in an amount that interferes with their progress or treatment. All medication administered to youth in these settings requires a written prescriber order or an oral order, if that order is noted in writing immediately and signed by the clinician within twenty-four hours. Behavior or symptomology prompting the administration must be documented in the medical record.[40]

Executive Summary, Practice: Investigative reports published by Searchlight New Mexico in 2018 provide scant information related to psychotropic medication prescription and administration to youth in the custody of CYFD. Journalists note that public records requests concerning those data were left unanswered or were refused by the Department. However, 2016 Medicaid pharmacy claims provided Searchlight New Mexico with a record of the regular practice regarding psychotropic medication prescription to children receiving Medicaid in New Mexico. Journalists found 10% of all children on Medicaid in New Mexico in 2016 were prescribed psychotropic medications, and in some cases, children younger than 5 years old were prescribed such medication.[41] According to a report of the same data by Results First, more than three percent of stimulants and seven percent of minor tranquilizers prescribed were for children under 5.[42]

Prescriber Issues: An individual prescriber in New Mexico who frequently provided medical services for youth in custody of CYFD was investigated in 2017 and 2018, in connection with the drug overdose deaths of 36 patients (ages unidentified), Medicaid fraud, and child abuse. The prescriber ultimately lost his license, but his prescription practices went unchecked for decades. Investigative reporter Amy Linn provides evidence that a critical lack of oversight contributed to the problem and details the danger children in CYFD custody faced as a result.[43,44]

Allegations regarding practice: Current litigation brought by thirteen foster children and by non-profit organizations on behalf of a class of children in the custody of CYFD alleges inadequate

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[38] N.M. Stat. § 32A-6A-15, Consent for Services, Ages 14 Years of Age or Older (2007). https://laws.nmonesource.com/w/nmos/Chapter-32A-NMSA-1978 N.M. Stat. § #!b/32A-6A-15.

[39] N.M. Stat. 32A-6A-17, Treatment Guardianship Proceedings (2007). https://laws.nmonesource.com/w/nmos/Chapter-32A-NMSA-1978#!b/32A-6A-17.

[40] N.M. Stat. § 32A-6A-12 (12), Personal Rights of a Child in an Out-of-Home Treatment or Habilitation Program (2007). https://laws.nmonesource.com/w/nmos/Chapter-32A-NMSA-1978#!b/32A-6A-12.

[41] Amy Linn, Searchlight New Mexico: Prescription for disaster: Lax oversight puts New Mexico kids in danger. *Santa Fe New Mexican* (October 18, 2018).

[42] Results First, Children's Behavioral Health Report presented to the NM Legislative Finance Committee (June 2017). https://www.nmlegis.gov/Entity/LFC/Documents/Results_First/Results%20First%20Children's%20Behavioral%20Health.pdf

[43] Amy Linn, Searchlight New Mexico: Drug Over-Prescription Plagues At-Risk Youths in NM. *Albuquerque Journal* (Nov 5, 2018). https://www.abqjournal.com/1241988/drug-overprescription-plagues-atrisk-youths-in-nm.html

[44] Amy Linn, Searchlight New Mexico: Warrant: Albuquerque psychiatrist over-medicated hundreds of children in his care. *Carlsbad Current Argus* (Oct. 30, 2018).

supervision and monitoring of psychotropic medications among children in CYFD custody. The complaint uses individual case examples to illustrate the following allegations:

- Psychotropic medications are routinely used as a method of chemical restraint for children in the custody of CYFD who demonstrate behavior symptoms of trauma exposure.
- There is no system in New Mexico to assess and monitor psychotropic medication prescriptions to children in the custody of CYFD.[45]

[45] Kevin S. et al. v. Jacobson et al., 1:18-cv-00896 (DNM 2018). http://ocr.docketalarm.com/cases/New_Mexico_District_Court/1--18-cv-00896/Kevin_S._et_al_v._Jacobson_et_al/

North Carolina: Ensuring that Youth in Out of Home Care are Only Prescribed Psychotropic Medication when it is in their Best Interests.

Executive Summary: North Carolina has sparse policy relating to the prescription of psychotropic medication for children in out-of-home custody with the North Carolina Child Welfare Agency, the Department of Social Services (DSS). Within the administrative code relating to medication for children and youth in custody, there is a single provision related to psychotropic medication.[46] The North Carolina General Statutes likewise provide details related to a single issue: consent for psychotropic medication prescription.[47] While not specific to children in out of home care, additional protections exist for children covered under Medicaid related to prescription for antipsychotic medication. A description of these provisions is provided below. Public information related to practice in the state is not readily available, although a good deal of recommendation and guidance does exist. Brief summaries of these documents are included in the information below.

Medication Review: A pharmacist or physician must review the psychotropic medication regimen of any child on Medicaid at least every six months. Foster parents are to arrange for psychotropic medication regimen review by the child's licensed medical provider at least every six months; they are required to report the findings of the drug regimen review to the supervising agency, and are responsible for documenting the drug review in the medication administrative record along with any prescribed changes.[48]

Consent: When a county department of social services has custody of a child, the director of social services has some authority to consent to health care for the child. This authority does not extend to psychotropic medication prescription, which is explicitly identified by the statute as a treatment that requires a court order based on clear and convincing evidence the treatment is in the child's best interests, absent parental consent.[49] The manner of consent required for a child coming into custody already on psychotropic medications is not clear from the statute.[50]

Protections for children that are beneficiaries under Medicaid through age 17, and North Carolina Health Choice, ages 6-17.

Monitoring: While not specific to children in out of home custody or to psychotropic medications, The NC Medicaid Outpatient Pharmacy Program requires the entry of basic information about the

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[46] 10A NCAC 70E .1102 MEDICATION, http://reports.oah.state.nc.us/ncac/title%2010a%20-%20health%20and%20human%20services/chapter%2070%20%20children's%20services/subchapter%20e/10a%20ncac%2070e%20.1102.doc

[47] N.C.G.S. 7B-505.1, 14 (2015). https://www.ncleg.net/EnactedLegislation/SessionLaws/PDF/2015-2016/SL2015-136.pdf

[48] 10A NCAC 70E .1102

[49] N.C.G.S. 7B-505.1, 14 (2015).

[50] In these circumstances, the UNC School of Government indicates that it is good practice to assess consent for psychotropic medication during the initial court hearing on the need for continued DSS custody, acquiring either parental consent or court order. Sara DePasquale, UNC Sch. Of Govt., Consenting to Medical Treatment for a Child Placed in the Custody of County Department, Part II: Non-routine and Non-emergency Medical Care (Blog Post, 2015).

patient, medication, dose, and diagnosis for children covered under Medicaid into the NCTracks provider portal.51

Additionally, the Division of Medical Assistance (DMA) requires prior authorization for antipsychotic medication prescription under certain circumstances for children through age 17 receiving Medicaid and children 6-17 covered under North Carolina Health Choice, pursuant to DMA Clinical Coverage Policy 9D.52 The requirements identified in the policy must be met in order for the prescriber to bill to Medicaid. This "safety monitoring . . . shall result when an antipsychotic medication is used without indications and dosage levels approved by the federal Food and Drug Administration (FDA)." Safety monitoring is also required for prescribed "interclass polypharmacy," a "combination therapy with two or more agents outside of a 60 calendar day window allowing for cross titration when converting agents."53 Safety monitoring shall target metabolic and neurologic side effects."54 Prior approval is required, data is required to be inputted by prescriber into a monitoring portal, and safety monitoring documentation is required.

Provider Education: Under DMA Clinical Coverage Policy 9D, prescribers are provided training and review of their recent prescribing data. "The initial education will focus on clinical issues related to the use of antipsychotics in children, including levels of evidence for use, safety and outcomes assessments, use of psychosocial supports, and interventions to consider if adverse effects present during antipsychotic therapy. Subsequent education will focus on clinical issues identified either statewide or at the specific practice level. Child psychiatry specialists shall be available as needed for consultative support."55

Practice: Although specific details are not known, the Child Welfare Reform Plan, created by the Office of State Budget and Management, with the NC Department of Health and Human Services indicates that "parents in North Carolina are not consistently provided with the opportunity to participate in medical appointments with their children in foster care, and too many barriers exist to the timely provision of needed mental health services for children in foster care."56 Data specific to psychotropic prescriptions to children in the custody of DSS was not available.

Policy Recommendations: While policy addressing psychotropic medication prescription among children in foster care is sparse in NC, DSS has investigated paths to policy reform. In 2014, the North Carolina Pediatric Society created the Health Oversight & Coordination Plan (HOCP) for North Carolina, at the request of DSS. HOCP was meant to move the state toward compliance with federal requirements regarding psychotropic medication oversight among children in foster care. The plan that was developed recommended a comprehensive psychotropic medication protocol based on the standards identified in the American Academy of Child and Adolescent Psychiatry and the Texas Psychotropic Medication Utilization Parameters for Foster Children Workgroup,

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[51] NC Tracks: Provider Policies, Manuals, Guidelines and Forms. https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

[52] NC Div. of Med. Assistance, Clinical Coverage Policy No: 9D, Off-label Antipsychotic Safety for Monitoring in Beneficiaries through age 17 (2019).

[53] *Id.*, p. 4

[54] *Id.*, p. 1

[55] *Id.* p. 5

[56] State of NC Office of State Budget and Mngmt with Dept of Health and Human Svcs., Child Welfare Reform Plan (2019) at 15. https://files.nc.gov/ncosbm/documents/files/ChildWelfareReform_FinalPlan.pdf.

among others.[57]

In 2017, Wayne Black, former NC Senior Director of Social Services and County Operations for the Department of Social Services, published communication to NC County Directors of Social Services pointing out best practice guidance documents available to assist them.[58] The letter notes that federal law requires protocols for appropriate use and monitoring of psychotropic medications for children in DSS custody,[59] provides recommendations regarding monitoring, documentation, and training, and includes two appended documents: The Best Practices for Medication Management for Children & Adolescents in Foster Care[60] and Psychotropic Medications in Children and Adolescents: Guide for Use and Monitoring.[61]

All of this information was provided in order to assist local DSS offices to individually become compliant with federal law.

In May of 2019 the State of North Carolina Office of State Budget and Management (OSBM) with the Department of Health and Human Services (DHHS) issued the Child Welfare Reform Plan (Reform Plan). Although psychotropic medication prescription to children in DSS custody is not mentioned in the Reform Plan, inconsistent policy development and dissemination are identified as issues ripe for reform. The authors note that DSS has been "considering and analyzing possible practice models to develop a statewide, standardized approach."[62] Appended to the Reform Plan is a 2019 DHHS Legislative Report, titled: "Plan for Regional Supervision and Support of Social Services and Child Welfare Programs." This plan was developed in accordance with a law passed in 2017 requiring that DHHS develop a plan to recommend legislative and other changes to improve the supervision and accountability of DSS. The plan recommends that DSS hire policy staff to provide support to counties and technical writers to support policy staff in creating and updating policy supporting child welfare and social services.[63]

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[57] Dana Hagele, & Leslie Starsoneck, NC Pediatric Society, NC Foster Care Health Oversight and Coordination Plan (2014). https://files.nc.gov/ncdhhs/documents/files/dss/statistics/Appendix-1-NC-Health-Oversight-and-Coordination-Plan.pdf

[58] Letter from Wayne Black, Psychotropic Medication Oversight and Monitoring (2017). https://cdn.ymaws.com/www.ncpeds.org/resource/collection/B444DBDE-60FE-4DCA-9042-E30F419B3767/DCDL_Psychotropic_Medication_Oversight_&_Monitoring_7-17-17.pdf

[59] Public Law 112-34 - The Child and Family Services Improvement and Innovation Act

[60] Community Care of North Carolina, Best Practices for Medication Management for Children and Adolescents in Foster Care (2015). https://www.communitycarenc.org/media/files/fostercare-medication-management-oct.pdf.

[61] Jerry McKee, Psychotropic Medications in Children and Adolescents: Guide for Use and Monitoring (2017).

[62] State of NC Office of State Budget and Mngmt with Dept of Health and Human Svcs., Child Welfare Reform Plan (2019) at 16. https://files.nc.gov/ncosbm/documents/files/ChildWelfareReform_FinalPlan.pdf.

[63] Dept of Health and Human Svcs, Plan for Regional Supervision and Support of Social Services and Child Welfare Programs, Session Law 2017-41 (2019) https://files.nc.gov/ncosbm/documents/files/ChildWelfareReform_FinalPlan.pdf

Tennessee Policy: Ensuring that Youth in Out of Home Care are only Prescribed Psychotropic Medication when it is in their Best Interests.

Executive Summary, Policy: The state of Tennessee has developed policy relating to the prescription of psychotropic medication for children in out-of-home care. The Tennessee Department of Children's Services, referred throughout this document as DCS and the Department, last revised DCS Policy 20.18 in 2011. The policy requires that psychotropic medication for youth in state's custody are prescribed and administered "in accordance with all applicable state and federal laws and in keeping with best clinical practices."[64] DCS and private providers are required to "regulate the handling and administration of psychotropic medications in accordance with professional standards of care, good security practices, and appropriate state and federal laws." [65] The information below provides a historical context for current policy and current policy parameters.

Historical Context: In 2000, a lawsuit filed on behalf of children in state's custody caused the Tennessee child welfare system to come under scrutiny. The prescription of psychotropic medications to children in DCS custody was identified as one area of critical concern. As a result of the subsequent settlement agreement, The DCS, Tennessee's Child Welfare Agency, hired a full-time medical director to help shepherd into existence key policies to support appropriate psychotropic prescription among children and youth in custody. [66,67]

Psychotropic Medication Definition: Psychotropic medication is defined by Tennessee statute[68] and in Tennessee DCS policy as a "medication that exercises a direct effect upon the central nervous system and which is capable of influencing and modifying behavior and mental activity. Psychotropic medications include, but are not limited to anti-psychotics; antidepressants; agents for control of mania and depression; anti-anxiety agents; psychomotor stimulants and hypnotics." [69]

Prohibitions: DCS Policy 20.18 provides that the use of psychotropic medication is "prohibited for experimentation, research, or discipline, coercion, retaliation, convenience of staff or as a

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[64] Tenn, DCS Admin. Pol. No. 20.18, Psychotropic Medication (2011) at 1. https://files.dcs.tn.gov/policies/chap20/20.18.pdf.

[2] *Id.*

[66] Brian A v. Haslam, Civ.Act.No. 3:00-0445 (M.D.Tenn. May 10, 2000); See also https://www.childrensrights.org/wp-content/uploads/2008/06/2000-05-10_tn_briana_complaint.pdf

[67] Prescription Psychotropic Use Among Children in Foster Care: Hearing Before the Subcomm. on Income, Security and Family Support, 110 Cong. 83 (2008) (Statement of Tricia Lea, Ph.D.).

[68] Tenn. Code § 49-2-124 (2): Psychotropic medication means a drug that exercises a direct effect upon the central nervous system and that is capable of influencing and modifying behavior. Psychotropic medication includes, but is not limited to: (A) Antipsychotics; (B) Antidepressants; (C) Agents for control of mania and depression; (D) Antianxiety agents; (E) Psychomotor stimulants; and (F) Hypnotics.

[69] Tenn DCS Admin. Pol. 20.18, Psychotropic Medication (2011).

substitute for appropriate programming. The use of psychotropic medication for the purpose of chemical restraint, or immobilization, for any child/youth in the care of DCS is prohibited." [70]

Prescription Parameters: DCS Policy indicates that only a licensed physician or nurse practitioner is qualified to prescribe psychotropic medications, and consultation with a board-certified child and adolescent psychiatrist should be sought in complex cases. A thorough examination should precede initial prescription, and the prescription *must* be accompanied "by an explanation that includes the need related to the child/youth's mental health diagnosis, potential side effects, as well as risks and benefits of the medication versus not taking the medication."[71] A specific form[72] is provided to aid the required documentation, although the policy provides that an equivalent form may be used.

Informed Consent: DCS Policy 20.24 details requirements and procedures regarding consent for medical tests, treatment, and medication prescription.[73] Part H of the policy provides specific procedures for obtaining consent for medication prescribed to treat a mental health condition or used as a psychotropic medication for children in state's custody.

Parent(s) are engaged in medical decision making, unless parental rights have been terminated, or the youth is aged 16 years or older. For youth under the age of 16, parents are to be contacted by the Family Social Worker managing the child's case, or by the appropriate DCS designee. This individual is to notify parent(s) of psychiatric appointments directly in person, by phone, or by mail and request parental participation at the psychiatric appointment.

Youth over the age of 16 have the right to determine whether their parents will be involved in psychiatric appointments and psychotropic medication decisions. DCS Staff is charged with communicating this option to the youth over age 16.

Information about the psychotropic medication to be prescribed should be shared with the parent or youth aged 16 or older, and consent should be documented on DCS Form 0627, called "Informed Consent for Psychotropic Medication."[74] This form should follow the child as he or she changes placements in DCS custody.

Verbal consent is allowable if the medical decision maker is not available to provide written consent. Specific documentation is required to document verbal consent. If the medical decision maker is not available to consent in person or by telephone, the DCS Regional Nurse has responsibility for providing consent. If the child is hospitalized in an acute or sub-acute

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[70] *Id.* at 1.
[71] *Id.* at 2.
[72] Tenn, DCS Form No. CS-0629 Psychotropic Medication Evaluation, https://files.dcs.tn.gov/forms/0629.doc.
[73] Tenn, DCS Admin. Pol. No. 20.24 Informed Consent (2018). https://files.dcs.tn.gov/policies/chap20/20.24.pdf.
[74] Tenn, DCS Form No. CS-0627 Informed Consent for Psychotropic Medication. https://files.dcs.tn.gov/forms/0627.doc.

psychiatric setting, and the medical decision maker cannot be located within 4 hours (or less, if late in the day), or if urgent consent is needed outside of regular business hours, then the DCS Regional Nurse should be consulted for consent. If the Regional Nurse provides consent, then the Regional Nurse is to notify the Family Social Worker staffing the child's case, who in turn will notify the parent(s), provided the child is under the age of 16. Children older than 16 must authorize parental notification.

DCS Policy provides that consent for specific psychotropic medications expires 14 days after a medication is stopped. Changes in prescription dosage or discontinuation are communicated to the Regional Nurse regardless of whether consent is required.

Youth over 16 entering DCS custody and parent(s) of children younger than 16 who come into custody with a current prescription for psychotropic medication consent to continue the medication. Consent is documented on DCS Form CS-0627, Informed Consent for Psychotropic Medication.[75] If the medical decision maker refuses to consent, then the Regional Nurse can provide consent until the child can be evaluated further.

> **Refusal:** Individuals refusing treatment are to be counseled on possible outcomes of non-treatment, and are asked to sign DCS Form CS-0093- Release from Medical Responsibility.[76] If a youth refuses to sign the document, notations are made by the designated staff person.
>
> In the event of refusal, DCS is to consult with provider to identify circumstances surrounding refusal.[77]
>
> **Exception to Consent:** Emergency administration of psychotropic medication to a child in DCS custody can occur without consent, but must be authorized by a licensed provider or a physician's order,[78] and is only allowable for a child that is hospitalized or placed in a Psychiatric Residential Treatment Facility (PRTF). Emergency psychotropic medication can only be authorized for a one-time dose, and should only be administered to treat an underlying psychiatric condition, and cannot be used to immobilize a child or to provide behavioral control.[79] As soon as possible, but at least within 24 hours of

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[75] *Id.*
[76] Tenn, DCS Form No. CS-0093 Release from Medical Responsibility https://files.dcs.tn.gov/intranet/forms/0093.pdf
[77] Tenn. DCS Admin. Pol. No. 20.24 Informed Consent at 7 requires the following documentation in the event of refusal: 1. Medical necessity of treatment, 2. Possible harm to the child that might occur with non-treatment, and 3. Alternative treatments available. In the case of a refusal by a minor aged 16 or older, the provider must determine whether the minor is mature enough to make an informed medical decision. If the minor is determined to be not mature enough, then parental consent is sought for treatment. Judicial intervention may be sought to advance treatment in cases where the treatment is necessary "to protect the child from harm and having the treatment is in the best interests of the child." Available at https://files.dcs.tn.gov/policies/chap20/20.24.pdf.
[78] *Id.*
[79] Tenn. DCS Admin. Pol. No 20.18, Psychotropic Medication (2011).

emergency psychotropic medication administration, the FSW, parent and Regional Nurse should be notified of the administration.[80]

Emergency Administration Monitoring and Evaluation: A child who is administered a one-time dose of psychotropic medication in an emergency is to be monitored for response to medication. Every 15 minutes for one hour, a registered nurse is to evaluate the child's mental status and vital signs as well as signs or symptoms of adverse reactions. Additionally, "[a] designated staff member (other than the registered nurse) who is in the immediate physical presence and in the same room as the child/youth and who is trained to monitor emergently medicated children/youth must continuously observe the child/youth. Particular attention must be given to safety issues such as falls. This monitoring will continue for the time frame defined by the licensed prescribing provider or for two hours if not specified. Routine monitoring will occur thereafter." A debriefing regarding the emergency administration is required within 24 hours following the administration with the child and facility staff.[81]

Emergency Administration Notification Procedures: Emergency administration of psychotropic medication shall be recorded as a serious incident within 24 hours on-line or on DCS Form CS-0496, "Serious Incident Report,"[82] following the procedures identified in DCS Policy 1.4, "Incident Reporting."[83] Incident reporting is relayed to DCS personnel, including the Regional Nurse, the FSW and DCS Central Office staff. Parents must be notified within 24 hours. The DCS Chief Medical Officer reviews each emergency use of psychotropic medication.[84]

Emergency Administration Documentation: The child's health record shall include a treatment plan that was in place prior to the emergency, with a provision for the potential use of emergency psychotropic medication administration. Additionally, documentation of the following is required: Procedures that were attempted prior to medication administration, clinical justification for the administration, administration details (i.e.: route, location of injection, response), observation data gathered following administration, and details regarding the debriefing.[85]

PRN Psychotropic Medication: Informed consent, consistent with DCS Policy 20.24,[86] is required prior to administration of PRN psychotropic medication.

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[80] Tenn. DCS Admin. Pol. No 20.24 Informed Consent (2018).
[81] Tenn. DCS Admin. Pol. No 20.18, Psychotropic Medication, (2011) at 3.
[82] Tenn. DCS Form CS-0496, Serious Incident Report, https://files.dcs.tn.gov/forms/0496.doc
[83] Tenn. DCS Admin. Pol. No 1.4 Incident Reporting. https://files.dcs.tn.gov/policies/chap1/1.4.pdf
[84] Tenn. DCS Admin. Pol. No 20.18, Psychotropic Medication (2011).
[85] *Id.*
[86] Tenn. DCS Admin. Pol. No 20.24, Informed Consent, (2018).

Prior Approval of Anxiolytic-Hypnotic and Antipsychotic Medications: In addition to informed consent, medications that are categorized as Anxiolytic-Hypnotic and Antipsychotic medications, identified and highlighted on an appended DCS list[87] generally require DCS prior approval in advance of administration. Prior approval must be documented on DCS Form CS 0628, "Request for Prior Approval of a PRN Psychotropic Medication" [88] or "in an equivalent manner." [89] The form or documentation must indicate the condition that the PRN medication is meant to treat, other interventions that have been used, other medications the child is taking, the time period the medication will be used (not to exceed 14 days), and how often the medication will be administered. The form or documentation is to be submitted to the Regional Nurse and forwarded to the DCS Chief Medical Officer or designee. Any PRN renewal request must be resubmitted, and the continuing need must be identified. While DCS prior approval is generally required for Anxiolytic-Hypnotic and Antipsychotic medication administration, policy 20.18 provides an exception for "One time orders for additional dosages of the child or youth's current medication," that may be used in order to assist in sleep or to assist a child during an intense emotional period. [90] Psychotropic medications not included in the categories of Anxiolytic-Hypnotic and Antipsychotic medications according to the DCS list appended to the Policy 20.18[91] do not require DCS prior approval.[92]

Medication Errors and Tracking: Medication errors are to be reported following DCS Policy 20.59 "Medication Error Guidelines"[93] and DCS Policy 1.4, "Incident Reporting."[94]

Psychotropic Medication Monitoring: As indicated in earlier sections of this document, the Department tracks details of psychotropic medication prescription to children in state's custody through the DCS Regional Nurse or Youth Development Center nursing staff. DCS also keeps an electronic record with prescription data and data related to informed consent (TFACTS). The Department indicates in Policy 20.18 that all facilities that contract with the agency must comply with the Tennessee Department of Developmental Disabilities Provider Manual,[95] which otherwise applies to the care of persons with intellectual disabilities. The manual provides requirements similar to those identified in DCS Policy 20.18 and DCS Policy 20.24, but also

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[87] Appendix I Psychotropic Medication Name and Class Values, https://files.dcs.tn.gov/policies/chap20/App1PsychoMed.pdf
[88] Tenn. DCS Form CS 0628, "Request for Prior Approval of a PRN Psychotropic Medication." https://files.dcs.tn.gov/forms/0628.pdf
[89] Tenn DCS Admin. Pol.20.18, Psychotropic Medication at 4.
[90] *Id.*, at 5.
[91] Appendix I: Psychotropic Medication Name and Class Values. https://files.dcs.tn.gov/policies/chap20/App1PsychoMed.pdf
[92] Tenn. DCS Admin. Pol. No 20.18, Psychotropic Medication (2011).
[93] Tenn. DCS Admin. Pol. No 20.59, Medication Error Guidelines. https://files.dcs.tn.gov/policies/chap20/20.59.pdf
[94] Tenn. DCS Admin. Pol. No 1.4 Incident Reporting. https://files.dcs.tn.gov/policies/chap1/1.4.pdf
[95] Tennessee Department of Developmental Disabilities, Provider Manual (2014). https://www.tn.gov/content/dam/tn/didd/documents/providers/provider-manual/Provider_Manual.pdf

identifies required psychotropic medication training for staff and quarterly medical appointments for individuals prescribed psychotropic medications.

Psychotropic Medication Utilization Parameters for Children in State Custody: Additionally, the Department indicates that it relies on the Psychotropic Medication Utilization Parameters for Children in State Custody (Psychotropic Medication Parameters).[96] First created by the Texas Department of Health Services, DCS's Pharmacy and Therapeutics Committee adapted the guidelines for use in Tennessee. The Psychotropic Medication Parameters provide guidelines and rationale for policy as well as additional pharmaceutical protections for the children in state's custody. Among these protections are criteria that trigger a clinical review of a child's status. DCS Policy 20.18 indicates that cases that fall outside of the guidelines in the Psychotropic Medication Parameters are assessed by the Regional Nurse and the DCS Chief Medical Officer or the Officer's designee. According to the Parameters, the following circumstances would require supervisory scrutiny:

1) Absence of a thorough assessment of DSM-IV diagnosis in the child's medical record.
2) Four (4) or more psychotropic medications prescribed concomitantly.
   The prescription of side effect agents benztropine or diphenhydramine does not count toward the total psychotropic number.
3) The Psychotropic Medication Parameters document also contains guidelines related to polypharmacy, which is defined as "the use of two or more medications for the same indication (i.e., specific mental disorder)."[97] In general, a single psychotropic medication should be utilized to treat a specific condition or symptom before a polypharmacy regimen is administered. As such, the following prescriptions will draw scrutiny under the Parameters:
   a) Two (2) or more concomitant antidepressants,
   b) Two (2) or more concomitant antipsychotic medications,
   c) Two (2) or more concomitant stimulant medications, or
   d) Two (2) or more concomitant mood stabilizer medications.
   -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.
4) The prescribed psychotropic medication is not consistent with the patient's diagnosis or the patient's target symptoms (i.e., specific symptoms observed in a

[96] Texas Department of Health Services, Psychotropic Medication Utilization Parameters for Children in State Custody, as Adapted by the Tennessee Department of Children's Services, Pharmacy and Therapeutics Committee. https://files.dcs.tn.gov/policies/chap20/PsychoMedUtilGuide.pdf
[97] *Id*. at 5.

child/adolescent that are associated with a mental disorder, and that usually respond to the medication being prescribed).

5) Psychotropic polypharmacy for a given mental disorder is prescribed before utilizing psychotropic monotherapy.
6) The psychotropic medication dose exceeds usually recommended doses.
7) Psychotropic medications are prescribed for children five (5) years and under.
8) Prescribing by a primary care provider for a diagnosis other than the following single DSM-IV TR Axis I diagnoses (unless recommended by a consultant in the specialties of: pediatric neurology, psychiatry, or developmental behavioral pediatrics).
   - Attention Deficit Hyperactivity Disorder (ADHD)
   - Encopresis
   - Enuresis
   - Mild-moderate anxiety disorders,
   - Mild-moderate depression,
   - Mild-moderate developmental disorders
   - Mild-moderate sleep disorders
   - Mild-moderate tic disorders.[98]

Tennessee Practice: Ensuring that Youth in Out of Home Care are Only Prescribed Psychotropic Medication when it is in their Best Interests.

Executive Summary, Practices: Owing to the judicial oversight following the Brian A settlement agreement,[99] much of current practice related to Tennessee psychotropic medication policy for youth in custody is well documented. Both the Technical Assistance Committee (TAC), organized pursuant to the Modified Settlement Agreement and Exit Plan in Brian A. v. Haslam,[100] and the external Accountability Center, part of the Center for State Child Welfare Data at Chapin Hall at the University of Chicago, which built on the work of the TAC, have documented Tennessee's progress since 2000. In April 2016, DCS reached all of the mandated milestones identified under the settlement agreement. The final TAC Monitoring Report was released in March of 2017,[101] which was followed by a yearlong period where Tennessee maintained its gains. After that period, the external Accountability Center issued three reports

[98] *Id.*at 5-6.
[99] Brian A .v Haslam Settlement Agreement https://www.tn.gov/dcs/program-areas/qi/policies-reports-manuals/brian-a.html.
[100] Formed in 2003 as result of ongoing judicial oversight, the Technical Assistance Committee was court-appointed panel of five national child welfare experts. The TAC was charged with advising on the implementation of the settlement agreement and monitoring DCS performance. https://www.childrensrights.org/class_action/tennessee/
[101] TECHNICAL ASSISTANCE COMMITTEE, MONITORING REPORT OF THE TECHNICAL ASSISTANCE COMMITTEE IN THE CASE OF BRIAN A. V. HASLAM (March 28, 2017). http://www.childrensrights.org/wp-content/uploads/2017/04/2017.04.04-Dkt.-No.-576-1-MR15.pdf

continuing to analyze DCS's progress.[102] Data from these final reports is included below. DCS's judicial oversight was concluded in February 2019.

Prevalence of Psychotropic Prescription: The Accountability Center's report provides psychotropic prescription prevalence data over recent years among children in DCS custody in Tennessee.

> "During 2017, the proportion of children with at least one day in care with at least one psychotropic medication prescription was 28 percent. This is a slight decline from reporting by the AC and the TAC for calendar years 2015 and 2016, when the proportion was 31 percent and 32 percent, respectively. Looking at the 2017 population by age at the time of the prescription, these figures were six percent for children ages 0-5, 29 percent for children ages 6-10, 43 percent for children ages 11-14, and 54 percent for children ages 15-17. According to the same report, the average number of medications was just under two, and the majority of medication types were antidepressants (32 percent) and stimulants (27 percent). However, as DCS recognizes, this current way of understanding this important issue is very limited. First, these current measures likely overstate the use of psychotropic medications because they include a point-in-time population which will consist of more long-staying children who might be more likely to have behavioral health issues to be addressed. Second, the measure also does not account for children who were already on such medications when they entered or reentered state custody, or changes in the use of these medications during custody, such as the likelihood that a child will start on a psychotropic medication during placement.[103]

Informed Consent: In TAC's 2016 Monitoring Report data, it identified higher levels of informed consent documentation than had been documented previously. In sampling data from of psychotropic medication prescriptions, TAC found an 84% informed consent documentation rate within 30 days of prescription. Documentation of approval for continued administration for children entering custody was found in 100% of the sample. At the time of the review, TAC noted that DCS was working with an external consultant to shore up vulnerabilities in the informed consent process.[104]

Prescriber Education and Training: The Accountability Center's 2018 report indicates that a Vanderbilt's Biostatistics team created a statistical model that was fine-tuned with input from a stakeholder group, which included prescribers, to identify prescribers with prescription practices that fell outside the norm. Using a consensus approach, the stakeholder group identified a process to increase awareness among these prescribers to ask them to reflect on prescriber

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[102] THE CENTER FOR STATE CHILD WELFARE DATA, TENNESSEE ACCOUNTABILITY CENTER REPORT 3 (December 2018). https://fcda.chapinhall.org/wp-content/uploads/2018/12/Tennessee_Accountability_Center_Report3.pdf

[103] *Id.* at 68.

[104] TECHNICAL ASSISTANCE COMMITTEE, MONITORING REPORT OF THE TECHNICAL ASSISTANCE COMMITTEE IN THE CASE OF BRIAN A. V. HASLAM (March 28, 2017) at 167-168.

behavior and external factors that might be contributing to their atypical prescription rates. According to the Accountability Center, the stakeholder team planned to run the statistical analyses on current prescribers in early 2019, report back to DCS, and then begin prescriber intervention in mid-2019.[105]

In terms of education and pre-service training, DCS uses a Psychotropic Medication Policy Training Curriculum that is available from the Department. The training is used to train all contract providers and DCS staff prior to service. DCS staff are required to complete a review course on the training every two years.[106]

Monitoring: DCS Regional Nurses review psychotropic medication prescription for children entering DCS custody, and provide on-going monitoring for children in custody. In cases that meet criteria for additional scrutiny (i.e: prescriptions for more than two medications of the same class, for more than four medications, that exceed the maximum dose, or are for a child under age 6), the Department engages with university affiliated Centers of Excellence (COE) to perform tracking and monitoring of psychotropic medication prescription oversight. The "red flag team" is made up of COE Psychiatric Mental Health Nurse Practitioners supported by a child psychiatrist and DCS regional nurses. According to TAC, as recently as 2015, the DCS Medical Director met "weekly with the 'red flag team' to discuss any problematic cases not already brought to the Medical Director's attention and to problem solve any systemic issues identified."[107] According to the Tennessee Child and Family Service Plan (2015-2019), the Medical Director is a full-time Child and Adolescent Psychiatrist.[108]

According to data reviewed by the Accountability Center, in 2017-2018, "these teams conducted 247 initial reviews of children's medication regimens and 55 secondary reviews of medication regimens that had been previously reviewed. The team's review resulted in disapproval of a particular medication regimen in 13 percent of the 247 cases reviewed for the first time."[109]

Centers of Excellence (COE): In addition to providing "red flag" oversight for unusual psychotropic medication prescription, the COE provides "consultation and evaluation for children with complex behavioral and medical problems." In some cases, the COE can provide direct

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[105] THE CENTER FOR STATE CHILD WELFARE DATA, TENNESSEE ACCOUNTABILITY CENTER REPORT 3 (December 2018).
[106] DCS Child and Fam. Svs. Plan, Appendix B- Tenn, DCS Coordination of Health Care Oversight and Coordination Plan (2015) at 2. https://www.tn.gov/content/dam/tn/dcs/documents/quality_improvement/federal-initiatives/TDCS_CFSP_Appen_B-Health_Care_Oversight_Coord_Plan.docx
[107] TECHNICAL ASSISTANCE COMMITTEE, at 167.
[108] DCS Child and Fam. Svs. Plan, Appendix B- Tenn, DCS Coordination of Health Care Oversight and Coordination Plan (2015).
[109] THE CENTER FOR STATE CHILD WELFARE DATA, at 68.

services, including medication management, according to the DCS Child and Family Services Plan 2015-2019.[110]

[110] DCS Child and Fam. Svs. Plan, Appendix B- Tenn, DCS Coordination of Health Care Oversight and Coordination Plan (2015) at 2.