Statement by

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Chairman Reichert, Ranking Member Doggett, and members of the Subcommittee, thank you for inviting me to testify. The Administration is very concerned about the over-medication of children in the foster care system. We are grateful to you for having this hearing and bringing more attention to the issue.

I am Joo Yeun Chang, Associate Commissioner of the Children's Bureau. I have worked as a national advocate on child welfare policies both as a senior staff attorney at the Children's Defense Fund and immediately prior to my appointment to the Bureau, I worked at Casey Family Programs Foundation where I worked closely with state and local child welfare agencies. In my current role, I oversee the Federal foster care and adoption assistance programs as well as a range of prevention and post-permanency initiatives.

At the Department of Health and Human Services (HHS), we are working with the state agencies that run child welfare systems to ensure that the vulnerable children in their care receive the proper medication. As victims of abuse or neglect, these children often need help dealing with their difficult experiences and, in recent years, the abiding impacts of traumatic experiences has become clearer through research.

Children who come into foster care often have been exposed to multiple acute and chronic traumas, including abuse or neglect and subsequent removal from their homes. The Centers for Disease Control and Prevention's Adverse Childhood Experiences Study and other research studies tell us that the impacts of these adverse experiences affect children in all domains: cognitive functioning, physical health and development, emotional and behavioral functioning, and social functioning. We know from the research that children who enter foster care are at a much higher risk for developing both physical and emotional disorders and the child welfare system currently struggles to fully meet their needs. If inadequately treated, these experiences can lead to worsening health conditions and may hinder a foster parent's ability to meet the child's needs, potentially resulting in multiple placements. This lack of stability can lead to increasingly restrictive and costly placements and make it more difficult for that child to find a permanent family. These undesired outcomes can negatively impact the well-being of children and youth in foster care and also mean additional costs for the child welfare and other public systems.

The need for action in this area is evident. HHS data show that 18 percent of the children in foster care were taking one or more psychotropic medications at the time they were surveyed (NSCAW II data collected October 2009 through January 2011). The Government Accountability Office has estimated an even higher range of 21 to 39 percent. Children in foster care are prescribed psychotropic medications at far higher rates than other children served by Medicaid, and often in amounts that exceed those indicated in Food and Drug Administration-approved labeling for such drugs. Many psychotropic medications are not approved for use in children. And in the cases where they are approved for use in children, some of these medications are used off-label for other psychiatric conditions which are not approved for children.

We appreciate the important role that the Congress, led by this Committee, has played to bring attention to these issues. Specifically, the 2008 enactment of Fostering Connections to Success

and Increasing Adoptions Act, which required for the first time that child welfare agencies develop ongoing oversight and coordination of health care services for children in foster care to the more recent enactment of the Child and Family Services Improvement and Innovation Act in 2011 that requires states to report to the HHS protocols they have in place for monitoring the use of psychotropic medications.

We have worked across the agency, and collaboratively across the Department, to provide guidance to states on monitoring the use of psychotropic medications for children in foster care and have shared information about evidence-based interventions that address the underlying issues of trauma. For example:

In 2011, then Administration for Children, Youth and Families Commissioner Bryan Samuels testified before the Senate Committee on Homeland Security and Governmental Affairs about the importance of the issue and provided an update on HHS actions to that point.

In 2011, ACF, the Centers for Medicare & Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA) issued a Tri-Agency State Director letter to draw attention to the problem of inappropriate psychotropic medication use in foster care and to provide guidance about best practice approaches to medication oversight and monitoring.

In April 2012, ACF issued an Information Memorandum (IM) that helps states implement the new requirements of the Child and Family Services Improvement and Innovation Act and provides information on promoting the safe, appropriate, and effective use of psychotropic medication for children in foster care.

In spring 2012, ACF collaborated with CMS and SAMHSA on a three-part webinar series to help states with the development of the psychotropic medication oversight and monitoring components of their title IV-B plan.

In August 2012, ACF, CMS, and SAMHSA co-hosted a summit for state child welfare, Medicaid, and mental health officials on strengthening the management of psychotropic drugs for children in foster care.

In August 2012, CMS released an Information Bulletin containing additional information regarding managing the use of these drugs in vulnerable populations.

In July 2013, ACF, CMS, and SAMHSA issued another Tri-Agency State Director letter encouraging the integrated use of trauma-focused screening, functional assessments, and evidence-based practices to improve child well-being.

Since 2011, ACF has awarded a total of $24 million in 18 states and the District of Columbia to promote the use of evidence-based interventions to improve social and emotional well-being of children in foster care.

After conducting these activities, we reviewed the progress that had been made and saw that there was a practice gap that needed to be filled. Child welfare agencies did not have access to

the research-based, non-pharmacological, mental health treatments for the conditions for which many of these children were being medicated.

Therefore, along with CMS, we developed the proposal you see in the FY 2015 President's Budget, one we hope you will give thoughtful consideration.

The existing strong evidence-base in the area of trauma-informed psychosocial interventions warrants a large initial investment to expand access to effective interventions. The ACF proposal for $250 million over five years would fund infrastructure and capacity building, while the CMS investment of $500 million over five years would provide incentive payments to states that demonstrate measured improvement.

ACF's funded activities would include:

- Closely linking findings from screenings and assessments with the selection of appropriate interventions, and ongoing assessments would be used to monitor children's progress with treatment;
- Coordination between child welfare case planning and management and Medicaid, especially Early and Periodic Screening, Diagnosis, and Treatment (EPSDT);
- Training of child welfare staff, foster parents, adoptive parents, guardians, judges and clinicians to make informed choices about evidence-based trauma interventions for the children they work with and, for caregivers, to implement their roles in interventions that require strong home-based support. Beyond initial training, some interventions require booster trainings to ensure that fidelity to the models does not erode over time. The child welfare workforce also should develop literacy in the area of evidence-based practice to support the transition to evidence-based service delivery;
- Fidelity monitoring and ongoing coaching/supervision, which are critical to the delivery of evidence-based interventions. Without them, the integrity of the intervention is compromised, and expected results may not be achieved;
- Evaluation; and,
- Systems to support and improve coordination between state child welfare agencies, Medicaid, and behavioral health services.

CMS incentive payments would recognize state improvement through a combination of process and outcome measures that would be available to qualifying demonstration states. States would receive incentive payments for making improvements against a baseline of standardized, national outcome measures that could include an assessment of the appropriateness or overuse of psychotropic medications in foster youth, as well as measures employed to evaluate the impact of such use on youth in foster care.

This proposal presents a concerted effort to reduce over-prescription of psychotropic medications for these children by increasing the availability of evidence-based, psychosocial treatments that meet the complex needs of children who have experienced maltreatment. Increased access to timely and effective screening, assessment, and non-pharmaceutical treatment will reduce over-prescription of psychotropic medication as a first-line treatment strategy, improve their

emotional and behavioral health, and increase the likelihood that children in foster care will exit to positive, permanent settings, with the skills and resources they need to be successful in life.

The Administration looks forward to working with you to address this crucial issue and improve services to some of our most vulnerable young people.

Again, thank you for the opportunity to speak with you today. I would be happy to answer any questions.