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FOSTER CHILDREN

HHS Could Provide Additional Guidance to States Regarding Psychotropic Medications

Statement of Stephen Lord, Managing Director, Forensic Audits and Investigative Service Team

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GAO Highlights

Highlights of GAO-14-651T, a testimony before the Subcommittee on Human Resources, Committee on Ways and Means, House of Representatives

Why GAO Did This Study

Foster children have often been removed from abusive or neglectful homes and tend to have more mental-health conditions than other children. Treatment of these conditions may include psychotropic drugs, but the risks these drugs pose specifically to children are not well understood. This testimony discusses GAO's recent work on (1) the extent to which children in foster care are prescribed psychotropic medications, (2) federal and state actions to oversee psychotropic prescribing to children in foster care, and (3) the extent to which the use of psychotropic medications was supported by foster and medical records for selected case studies of children in foster care who were prescribed these medications. This testimony is based on previous GAO reports issued from 2011 through 2014 that used various methodologies, including reviewing federal studies, analyzing Medicaid prescription claims data from five states, and contracting with two experts to review 24 case files (selected, in part, based on potential health risk indicators). The findings related to the expert reviews of 24 case files are not generalizable.

What GAO Recommends

GAO has made recommendations in prior work, including that the Secretary of Health and Human Services issue guidance to state Medicaid, child-welfare, and mental-health officials regarding prescription-drug monitoring and oversight for children in foster care receiving psychotropic medications through MCOs. The Department of Health and Human Services (HHS) concurred with the recommendation and described planned actions.

View GAO-14-651T. For more information, contact Stephen Lord at (202) 512-6722 or lords@gao.gov or Katherine Iritani at (202) 512-7114 or iritanik@gao.gov.

What GAO Found

In December 2012, GAO reported on the results of the Administration for Children and Families (ACF) surveys of children in contact with the child-welfare system conducted during 2008-2011. 18 percent of foster-care children were taking a psychotropic medication at the time they were surveyed. Foster children who lived in group homes or residential treatment centers had much higher rates of psychotropic medication use than those living in nonrelative foster homes or formal kin care—48 percent versus 14 percent and 12 percent, respectively, according to the surveys. The higher utilization rate among children living in group homes or residential treatment centers may be related to these children having higher rates of potential mental-health need. Among foster children who took psychotropic medication, about 13 percent took three or more psychotropic medications concurrently. About 6.4 percent of foster children took an antipsychotic medication—psychotropic medications with potentially serious side effects that are intended to treat serious mental-health conditions such as schizophrenia—and the majority were ages 6 -11. In examining prescribing at the state level, GAO found similar results in its December 2011 review. Specifically, children in foster care in Florida, Massachusetts, Michigan, Oregon, and Texas were prescribed psychotropic medications at higher rates than nonfoster children in Medicaid during 2008, although prescribing rates varied by state.

In April 2014, GAO found the federal government and states have taken a multitude of steps to better oversee psychotropic drug prescribing for children in foster care, although more can be done as states increasingly deliver their medication benefits through Medicaid managed care. In addition, GAO found that, to varying degrees, each of the five selected states it reviewed had policies and procedures designed to address the monitoring and oversight of psychotropic medications prescribed to children in foster care. For example, all five selected states' foster-care programs use a screening tool that may prompt a referral of the foster child for a psychiatric evaluation. GAO also found that ACF had provided webinars and technical guidance to states. However, many states have, or are transitioning to, managed care organizations (MCO) to deliver Medicaid prescription-drug benefits, and GAO found variation in the extent that the five selected states were taking steps to plan for the oversight of drug prescribing for foster children receiving these benefits through MCOs.

For an April 2014 report, GAO contracted with two child psychiatrists to review foster and medical records for 24 cases in five selected states and found varying quality in the documentation supporting the use of psychotropic medications for children in foster care. These experts found that for many of the cases the prescriptions were mostly supported by documentation. However, in some areas, such as evidence-based therapies—interventions shown to produce measureable improvements—the experts found documentation was lacking. For example, the experts found that 3 of 15 children who may have benefited from such therapies were mostly provided such services, while in 11 of the 15 cases, the experts found that evidence-based therapies were partially provided but also found that other evidence-based therapies that may have been more applicable or beneficial were not provided, based on the documents reviewed. In 1 of the 15 cases there was no documentation that evidence-based therapies were provided.

Chairman Reichert, Ranking Member Doggett, and Members of the Subcommittee:

I am pleased to be here today to discuss our work examining the use of psychotropic drugs among children in foster care. Child mental-health advocates, providers, and researchers have expressed concerns about the increase in the prescribing of psychotropic medications (medications that affect mood, thought, or behavior) for children, in part because there is limited evidence available regarding short- and long-term safety and efficacy for some types of medications, particularly for combinations of these medications. Mental-health experts are especially concerned about the recent increase in the prescribing of antipsychotic medications—psychotropic medications that are intended to treat serious mental-health conditions such as schizophrenia and bipolar disorder—in part because these medications can cause serious side effects, such as rapid weight gain and the development of diabetes. Concerns about the increased prescribing of psychotropic medications may be compounded for children in foster care, who may be at higher risk of mental-health conditions than other children. Children in foster care are an especially vulnerable population because often they have been subjected to traumatic experiences involving abuse or neglect and they may suffer from multiple, serious mental-health conditions.[1]

Early detection and treatment of mental-health conditions can improve a child's symptoms and reduce potentially detrimental effects, such as difficulties with relationships, dropping out of school, and involvement with the juvenile justice system. Children with mental-health conditions, such as attention deficit hyperactivity disorder (ADHD) or depression, can be treated with psychosocial therapies (sessions with a provider designed to reduce symptoms and improve functioning); psychotropic medication; or a combination of both.

Several agencies in the Department of Health and Human Services (HHS) have responsibilities related to children's mental-health. The

[1]According to the Administration for Children and Families (ACF), 46 percent of children investigated by child welfare services came to the state's attention because of a report of neglect, and 27 percent had experienced physical abuse as the most serious form of maltreatment. See U.S. Department of Health and Human Services, Administration for Children and Families, National Survey of Child and Adolescent Well-Being (NSCAW), No. 7: *Special Health Care Needs Among Children in Child Welfare* (Washington, D.C.: Jan. 15, 2007).

Administration for Children and Families (ACF) provides funding for and oversees states' child-welfare programs, which are responsible for monitoring and coordinating mental-health services for children in foster care, among other things. The Centers for Medicare & Medicaid Services (CMS) oversees, and jointly finances with the states, the Medicaid program, which provides health coverage to most children in foster care.[2] State Medicaid programs are required by federal law to provide coverage for certain health services, which may include mental-health services, for children through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. The Substance Abuse and Mental Health Services Administration (SAMHSA) works to increase the quality and availability of mental-health services, such as by awarding grants that support the development of community-based services for children with mental-health conditions, including children in foster care.

My testimony today relates to the use of psychotropic drugs among children in foster care. Specifically, my remarks will focus on three areas:

- the extent to which children in foster care are prescribed psychotropic medications;
- federal and state actions to oversee psychotropic medication prescribing to children in foster care; and
- results from reviews of selected case studies of children in foster care who were prescribed these medications.

My statement is based on our previously issued reports, issued from December 2011 to April 2014, related to psychotropic medication prescribing among foster care children.[3] For this prior work, among other things, we described the results of ACF's National Survey of Child and Adolescent Well-being II (NSCAW II), a nationally representative

[2]Medicaid is a joint federal-state program that finances health-care coverage for certain low-income individuals.

[3]See GAO, *Foster Children: HHS Guidance Could Help States Improve Oversight of Psychotropic Prescriptions*, GAO-12-201 (Washington, D.C.: Dec. 14, 2011); *Children's Mental Health: Concerns Remain about Appropriate Services for Children in Medicaid and Foster Care*, GAO-13-15 (Washington, D.C.: Dec. 10, 2012); and *Foster Children: Additional Federal Guidance Could Help States Better Plan for Oversight of Psychotropic Medications Administered by Managed-Care Organizations*, GAO-14-362 (Washington, D.C.: Apr. 28, 2014). Each of these products contains detailed information on the various methodologies used in our work.

longitudinal survey of children ages 0 through 19 who were in contact with the child welfare system.[4] In addition, we analyzed 2008 Medicaid prescription drug claims and foster care data for five states (Florida, Massachusetts, Michigan, Oregon, and Texas), and contracted with two child psychiatrists to provide clinical evaluations of 24 cases.[5] The case selections were based, in part, on potential health risk indicators identified by experts. The cases cannot be generalized to the foster-care population. The reports cited in this statement each provide detailed information on our scope and methodology.

The work on which this statement is based was conducted in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our audit findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Children enter state foster care when they have been removed from their parents or guardians and placed under the responsibility of a state child-welfare agency. At the end of fiscal year 2012, approximately 400,000 children were living in foster care, mostly as a result of having experienced neglect or abuse by their parents.[6] When children are taken into foster care, the state's child-welfare agency becomes responsible for determining where the child should live and providing the child with needed support. The agency may place the foster child in the home of a relative, with unrelated foster parents, or in a group home or residential

[4]GAO-13-15; the NSCAW II surveys occurred in multiple phases during 2008 through 2011. See Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, *NSCAW II Baseline Report: Children's Services*, OPRE Report #2011-27f (Washington, D.C.: 2011) and Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, *Psychotropic Medication Use by Children in Child Welfare*, OPRE Report #2012-33 (Washington, D.C.: 2012).

[5]GAO-12-201; GAO-14-362.

[6]These are the most recent data available. See U.S. Department of Health and Human Services, *The AFCARS Report, Preliminary FY 2012 Estimates as of July 2013*, No. 20, (Washington, D.C.: November 2013).

treatment center, depending on the child's needs.[7] The agency is also responsible for arranging needed services, including mental-health services. Coordinating mental-health care for children in foster care may be difficult for both the medical provider and the caseworker depending on the complexity of the child's needs, and because multiple people are making decisions on a child's behalf. In addition, caseworkers in child-welfare agencies may have large caseloads, making it difficult for them to ensure each child under their authority receives adequate mental-health services.

In 2011, the Child and Family Services Improvement and Innovation Act amended the Social Security Act to require states to identify protocols for monitoring foster children's use of psychotropic medications and to address how emotional trauma associated with children's maltreatment and removal from their homes will be monitored and treated.[8] ACF requires states to address these issues in their required Annual Progress and Services Reports (APSR) and has provided guidance detailing how states are to address protocols for monitoring foster children's use of psychotropic medications as part of the state's APSR.[9] Among other things, state monitoring protocols are to address

- screening, assessment, and treatment planning to identify children's mental-health and trauma-treatment needs, including a psychiatric evaluation, as necessary, to identify needs for psychotropic medications;
- effective medication monitoring at both the client and agency level; and
- informed and shared decision making and methods for ongoing communication between the prescriber, the child, caregivers, other health-care providers, the child-welfare worker, and other key stakeholders.

[7]Group homes and residential treatment centers provide 24-hour care in a group setting to children with physical or behavioral needs. Residential treatment centers are inpatient facilities other than a hospital that provide specialized services to children, such as psychiatric services.

[8]Child and Family Services Improvement and Innovation Act, Pub. L. No. 112-34, § 101(b)(1) and (2), 125 Stat. 369 (amending 42 U.S.C. § 622(b)(15)(A)).

[9]See U.S. Department of Health and Human Services, Administration for Children and Families, Program Instruction ACYF-CB-PI-12-05 (Washington, D.C.: Apr. 11, 2012).

According to ACF, child-welfare systems that choose to pursue comprehensive and integrated approaches to screening, assessing, and addressing children's behavioral and mental-health needs—including the effects of childhood traumatic experiences—are more likely to increase children's sense of safety and provide them with effective care.

Children in foster care who are enrolled in Medicaid may receive services generally through one of two distinct service-delivery and financing systems—managed care or fee-for-service. Under a managed-care model, states may contract with a managed-care organization (MCO) and prospectively pay the MCO a fixed monthly fee per patient to provide or arrange for most health services, which may include prescription-drug benefits. The MCOs, in turn, pay providers. In the traditional fee-for-service delivery system, the Medicaid program reimburses providers directly and on a retrospective basis for each service delivered.

Children in Foster Care Receive Psychotropic Medications at Higher Rates than Other Children in Medicaid

In December 2012, we reported information on national levels of psychotropic drug use among foster care children based on the results of the NSCAW II.[10] According to the results from NSCAW II, 18 percent of foster-care children were taking a psychotropic medication at the time they were surveyed.[11] Additionally, foster children who lived in group homes or residential treatment centers had much higher rates of psychotropic medication use than foster children living in nonrelative foster homes or formal kin care—48 percent versus 14 percent and 12 percent, respectively.[12] The higher utilization rate among children living in group homes or residential treatment centers may be related to these children having higher rates of potential mental-health need—about 69

[10]GAO-13-15.

[11]In the survey, caregivers were asked whether the child was currently taking a psychotropic medication. Estimates for foster children refer to those who lived in nonrelative foster homes, formal kin care, group homes, or residential treatment centers.

[12]Based on data that ACF reported, about 50 percent of foster children lived in nonrelative foster homes, 41 percent lived in formal kin care arrangements, and 9 percent lived in group homes or residential treatment centers. U.S. Department of Health and Human Services, *Psychotropic Medication Use by Children in Child Welfare*, 2. Formal kin care is a living arrangement where the child is placed under legal custody of the state, but in physical custody of a relative. Differences in medication utilization by living arrangement are statistically significant and are based on NSCAW II phase 1 data (collected during March 2008 through September 2009). U.S. Department of Health and Human Services, *NSCAW II Baseline Report: Children's Services*, 45–46.

percent had a potential mental-health need compared to about 44 percent of children living in nonrelative foster homes.[13] Another study found that child welfare workers were more likely to place children with behavior problems in a group-living arrangement than with a foster family.[14] NSCAW II data showed that 30 percent of foster children with a potential mental-health need had not received any mental-health services, such as treatment at an outpatient mental-health center or with a mental-health professional or family doctor, within the previous 12 months or since the start of the child's living arrangement, if less than 12 months.[15]

In December 2012 we also found that in addition to reporting on overall use of psychotropic medications, the NSCAW II included information on concurrent use of psychotropic medications and on the use of antipsychotics by foster children. Among foster children who took psychotropic medication, 13 percent took three or more psychotropic medications concurrently.[16] The American Academy of Child & Adolescent Psychiatry (AACAP) has noted that there is a lack of research on the efficacy of taking multiple psychotropic medications concurrently. NSCAW II survey findings also showed that 6.4 percent of foster children took an antipsychotic medication and that the majority were ages 6 through 11.[17] Mental-health researchers and others have stated that there

[13]ACF's reports identified children with a potential mental-health need by selecting children whose scores were above a certain level on one of five standardized psychometric scales that were used in NSCAW II and were designed to measure emotional or behavioral problems. According to ACF, these scales are reliable assessments of children's behavioral and emotional problems.

[14]M. E. Courtney, "Correlates of Social Worker Decisions to Seek Treatment-Oriented Out-of-Home Care," *Children and Youth Services Review*, vol. 20, no. 4, (1998).

[15]Estimates of children with potential mental-health need who had not received mental-health services are based on NSCAW II phase 2 data (collected during October 2009 through January 2011). U.S. Department of Health and Human Services, *Psychotropic Medication Use by Children in Child Welfare*, 6.

[16]Estimates of concurrent use are based on NSCAW II phase 2 data (collected during October 2009 through January 2011). This estimate does not include children in formal kin care. U.S. Department of Health and Human Services, *Psychotropic Medication Use by Children in Child Welfare*, 4.

[17]Estimates of antipsychotic use are based on NSCAW II phase 2 data (collected during October 2009 through January 2011). This estimate does not include children in formal kin care. U.S. Department of Health and Human Services, *Psychotropic Medication Use by Children in Child Welfare*, 4.

is a need for further research on the safety and effectiveness of antipsychotics for children, particularly the long-term effects.

In December 2011, we reported findings from our analysis of five states' Medicaid prescription drug data that found children in foster care in Florida, Massachusetts, Michigan, Oregon, and Texas were prescribed psychotropic medications at higher rates than nonfoster children in Medicaid during 2008.[18] Specifically, we found that among these states foster children were prescribed psychotropic drugs at rates 2.7 to 4.5 times higher than were nonfoster children in Medicaid in 2008. The rates were higher among foster children for each of the age ranges—0 to 5 years old, 6 to 12 years old, and 13 to 17 years old—that we reviewed. According to research, experts we consulted, and certain federal and state officials we interviewed as part of our December 2011 report, this could be due in part to foster children's greater exposure to traumatic experiences, frequent changes in foster placements, and varying state oversight policies.

In our December 2011 report, we also found that prescriptions for foster children in these five states were more likely to have indicators of potential health risks. According to experts consulted, no evidence supports the concurrent use of five or more psychotropic drugs in adults or children, yet an analysis of Medicaid claims data suggested that hundreds of both foster and nonfoster children in these five states had such a drug regimen. Increasing the number of drugs used concurrently increases the likelihood of adverse reactions and long-term side effects, such as high cholesterol or diabetes, and limits the ability to assess which of multiple drugs are related to a particular treatment goal.[19] Similarly, in December 2011 we found that thousands of foster and nonfoster children in Medicaid were prescribed doses higher than the maximum levels cited in guidelines developed by Texas based on FDA-approved product labels

[18]GAO-12-201.

[19]See Julie M. Zito et al., *Psychotropic Medication Patterns Among Youth in Foster Care*, *Pediatrics.* vol.121, no. 1 (2008), 157–163.

or medical literature maximum dosages for children and adolescents.[20] Our experts said that this increases the risk of adverse side effects and does not typically increase the efficacy of the drugs to any significant extent.[21] Further, foster and nonfoster children under 1 year old were prescribed psychotropic drugs, which experts consulted said have no established use for mental-health conditions in infants and providing them these drugs could result in serious adverse effects. These experts also said that the prescriptions could have been prescribed for non-mental-health reasons, such as for seizures, and to treat allergies, itching, or other skin conditions.[22]

[20]Analysis included in our December 2011 report used dosage guidelines developed by the state of Texas based on FDA-approved or medical literature maximum dosages for children and adolescents. ACF lists these guidelines as an example for other states. For additional information, see GAO-12-201 and Texas Department of Family and Protective Services, and the University of Texas at Austin College of Pharmacy, *Psychotropic Medication Utilization Parameters for Foster Children* (Austin, Tex.: December 2010).

[21]The Food and Drug Administration (FDA), within HHS, approves drugs for use for specified indications, and these indications are set forth on the drugs' FDA-approved drug labels.

[22]Experts also noted that some of these prescriptions may have been written with the intention of treating an uninsured parent or sibling. It was not possible to determine from the data whether this was the case.

HHS and States Have Made Progress in Improving Oversight of Psychotropic Prescriptions, but Additional Guidance Could Help Officials Manage Psychotropic Medications

In December 2011, we found that six selected states' monitoring programs for psychotropic drugs provided to foster children fell short of best principles guidelines published by the AACAP.[23] The guidelines, which states were not required to follow at the time of this report, covered four categories.[24] The following describes the extent to which the selected states' monitoring programs in our review covered these areas.

- Consent: Each state had some practices consistent with AACAP consent guidelines such as identifying caregivers empowered to give consent.
- Oversight: Each state had procedures consistent with some but not all oversight guidelines, which include monitoring rates of prescriptions.
- Consultation: Five states had implemented some but not all guidelines, which include providing consultations by child psychiatrists by request.
- Information: Four states had created web-sites about psychotropic drugs for clinicians, foster parents, and other caregivers.

We found that this variation was expected because states set their own guidelines, and, at the time of our 2011 report, HHS had not yet endorsed specific measures for state oversight of psychotropic prescriptions for children in foster care. We recommended that HHS consider endorsing guidance for states on best practices for overseeing psychotropic prescriptions for children in foster care. HHS concurred with the recommendation and, in April 2012, issued guidance regarding the oversight of psychotropic medications among children in foster care. HHS has also undertaken collaborative efforts to provide guidance and promote information sharing among states.

In April 2014, we issued a follow-up report to, among other things, assess HHS actions taken since our 2011 report and describe selected states' policies related to psychotropic medication.[25] In addition to issuing the guidance we recommended, HHS efforts have focused on using mental-

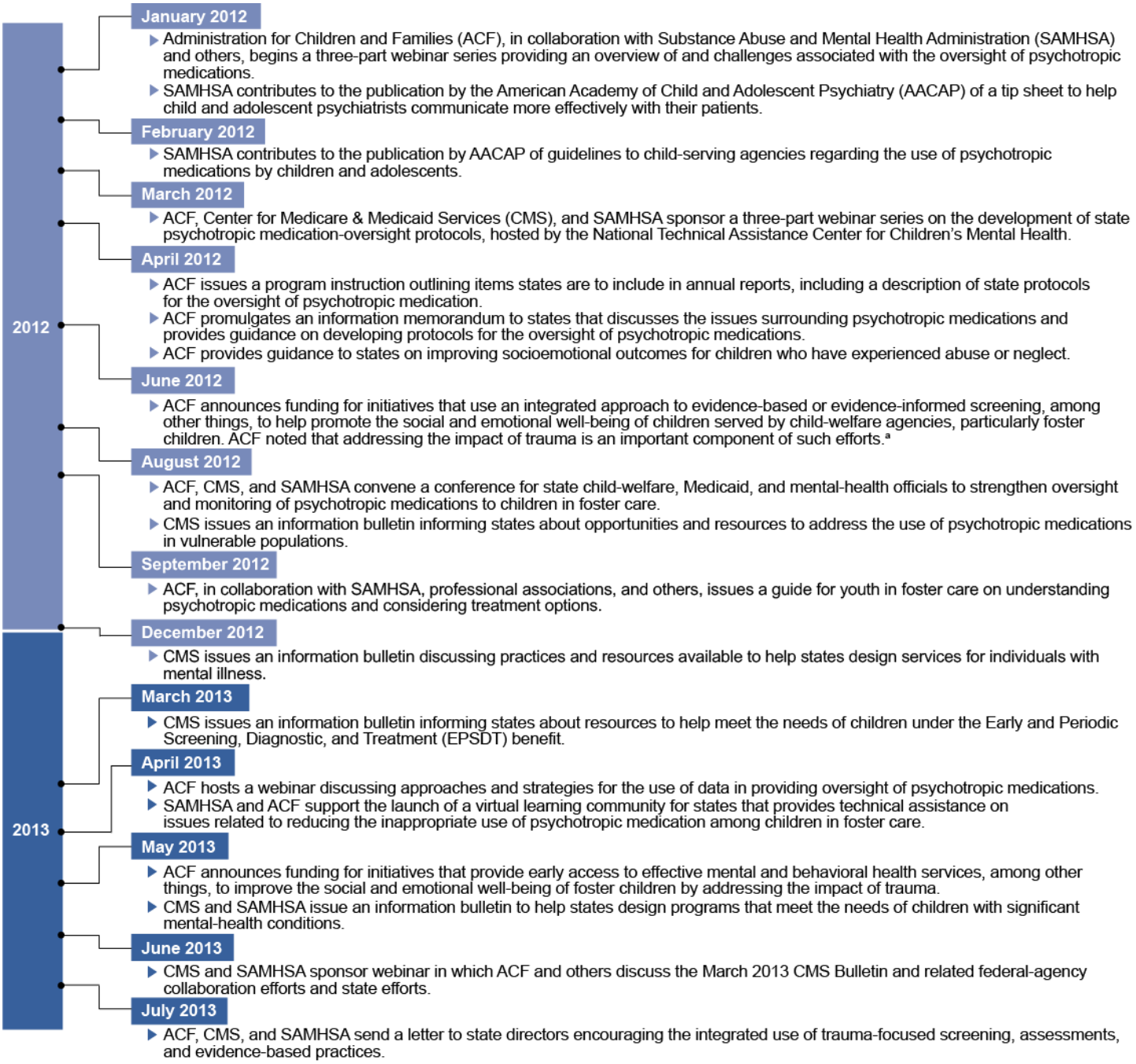
[23]GAO-12-201. The six selected states included Florida, Maryland, Massachusetts, Michigan, Oregon, and Texas.

[24]*AACAP Position Statement on Oversight of Psychotropic Medication Use for Children in State Custody: A Best Principles Guideline.*

[25]GAO-14-362.

health screening tools and providing therapies that address trauma, which seek to ensure that the mental-health needs of children in foster care are appropriately met. See figure 1 below for a list of initiatives undertaken since our December 2011 report by ACF, CMS, and SAMHSA.

Figure 1: Department of Health and Human Services (HHS) Efforts to Support States' Oversight of Psychotropic Medications among Children in Foster Care and Encourage the Use of Mental-Health Assessments and Screening Tools since December 2011



Source: GAO analysis of ACF, CMS, and SAMHSA documents and interviews.

In our April 2014 follow-up report, we also found that, to varying degrees, each of the five selected states we reviewed has policies and procedures designed to address the monitoring and oversight of psychotropic medications prescribed to children in foster care. For example:

- All five selected states' foster-care programs use some type of functional assessment or screening tool, such as the Child and Adolescent Needs and Strengths (CANS), for screening and treatment planning, which may prompt a referral for a psychiatric evaluation as deemed appropriate.
- All five of the selected states have designed a mechanism to coordinate and share some or all Medicaid prescription claims data with the state's foster-care agency to help monitor and review cases based on varying criteria, such as prescriptions for children under a particular age, high dosages, or concurrent use of multiple medications.

Three of five states—Florida, Massachusetts and Texas—included in our April 2014 review use, or are transitioning from fee-for-service to, MCOs to administer prescription-drug benefits for mental-health medications. Medicaid officials from two of those three states reported that their states had conducted limited planning to ensure appropriate oversight of MCOs administering psychotropic medications.

ACF, CMS, and SAMHSA have developed guidance for state Medicaid, child-welfare, and mental-health officials related to the oversight of psychotropic medications that underscored the need for collaboration between state officials to improve prescription monitoring. However, we found in April 2014 that this guidance does not address oversight within the context of a managed-care environment, in which states rely on a third party to administer benefits such as psychotropic medications. Many states have, or are transitioning to, MCOs to administer prescription-drug benefits, and, as our work demonstrates, selected states have taken limited steps to plan for the oversight of drug prescribing for foster children receiving health care through MCOs—which creates a risk that controls instituted in recent years under fee-for-service may not remain once states move to managed care. In our April 2014 report, we concluded that additional guidance from HHS that helps states prepare and implement monitoring efforts within the context of a managed-care environment could help ensure appropriate oversight of psychotropic medications to children in foster care. We recommended that the Secretary of Health and Human Services issue guidance to state

Medicaid, child-welfare, and mental-health officials regarding prescription-drug monitoring and oversight for children in foster care receiving psychotropic medications through MCOs. HHS concurred with the recommendation and described planned actions to address it, such as having CMS work with other involved agencies to coordinate guidance between CMS and other HHS agencies.

Case Studies Varied in Quality of Documentation Supporting the Use of Psychotropic Medications

Expert Reviews of Select Foster Children's Foster and Medical Files Found Variation in the Quality of Documentation

As part of our April 2014 report, we also contracted with two child psychiatrists to provide clinical evaluations of 24 cases that we selected from the population of foster children prescribed psychotropic drugs in 2008.[26] The case selections were based, in part, on potential health risk indicators, such as concurrent use of five or more psychotropic medications, doses higher than the maximum levels cited in guidelines developed by Texas based on FDA-approved labels or medical literature maximum dosages for children and adolescents, and children less than 1 year old prescribed psychotropic drugs. Our experts' reviews of 24 foster children's foster and medical files in five selected states found that the quality of documentation supporting the prescription of psychotropic medication usage varied with respect to (1) screening, assessment, and treatment planning; (2) medication monitoring; and (3) informed and shared decision making.

Screening, Assessment, and Treatment Planning. Our experts' evaluation of this category included whether medical pediatric exams and evidence-based therapies—which are interventions shown to produce measureable improvements—were provided as needed, according to

[26]GAO-14-362.

records.[27] Our experts found in 22 of 24 cases that medical pediatric exams were mostly supported by documentation. For example, in one case with mostly supporting documentation, experts found that a child with a history of behavioral and emotional problems had records documenting a medical pediatric exam and thorough psychological assessments, with comprehensive discussions of diagnostic issues and medication rationale. With regard to evidence-based therapies, experts found that 3 of 15 children who may have benefitted from such therapies were mostly provided such services. In 11 of 15 applicable cases, the experts found that evidence-based therapies were partially provided, such as for instances when some psychosocial or evidence-based therapies were documented, but other evidence-based therapies that may have been more applicable or beneficial were not provided. In 1 of 15 cases there was no documentation that evidence-based therapies were provided.

Medication Monitoring. Our experts' evaluation of this category included the appropriateness of medication dosage and the rationale for concurrent use of multiple medications, according to records. Our experts found appropriateness of medication dosages was mostly supported by documentation in 13 of 24 cases and partially supported in the other 11 cases. The rationale for concurrent use of multiple medications was mostly supported in 5 of the 20 cases where multiple medications were used, but 14 of 20 cases included documentation that partially supported concurrent use, and 1 case did not include documentation to support concurrent use. For example, in one case with partially supporting documentation, our experts found that a child was prescribed four psychotropic drugs concurrently, when nonmedication interventions could have been considered.

Informed and Shared Decision Making. Our experts' evaluation of this category included whether informed consent and communication between treatment providers occurred, according to records. Our experts found that informed-consent decisions were mostly documented in 5 of 23 applicable cases. In 11 of 23 cases, our experts found partial documentation of informed consent—such as when some, but not all, medications prescribed to the child included documentation of informed

[27]Psychosocial therapies that have been shown to be effective in treating mental-health conditions may be referred to as evidence-based therapies. Trauma-focused cognitive behavioral therapy is an example of an evidence-based therapy.

consent—and 7 other cases did not include any documentation of informed consent. For example, in one case, our experts reported there was no documentation of informed consent, psychiatric evaluation, psychiatric diagnosis, or monitoring of antipsychotic medication. In this case, the child was prescribed an antianxiety medication (buspirone), an antipsychotic medication (risperidone), and an ADHD medication (clonidine) at 4 years of age, presumably to treat psychiatric symptoms that interfered with his functioning, including short attention span, wandering off, self-injury, and aggression. However, our experts noted the documentation was too sparse to determine why the psychotropic medications were prescribed, and the indications, monitoring, and side effects could not be evaluated. In addition, our experts found that communication between treatment providers was mostly documented in 15 of 23 applicable cases. However, communication between treatment providers was partially documented in 5 of 23 cases, and there was no evidence that such communication occurred in 3 of 23 cases. Foster children can experience frequent changes in their living placements, which can lead to a lack of continuity in mental-health care, and new providers may not have the medical history of the patient. [28] This lack of stability can lead to treatment disruptions and can increase the number of medications prescribed.

Some Prescriptions in Infant Cases Were for Non-Mental-Health Reasons, but Others Were for Psychiatric or Unclear Reasons

Of the 24 cases reviewed, 9 were infant cases that our experts evaluated to determine whether the prescriptions were for psychiatric or non-mental-health reasons. Our experts agreed that prescriptions of psychotropic medications to infants carries significant risk as there are no established mental-health indications for the use of psychotropic medications in infants and the medications have the potential to result in serious adverse effects for this age group. Our experts found in 4 of 9 infant cases reviewed that the prescription of psychotropic medication was for non-mental-health purposes, such as to treat skin conditions, based on documentation reviewed. However, our experts found that in 2 of 9 cases the infants were prescribed psychotropic medications for psychiatric

[28]ACF reported that foster children moved an average of 1.6 times in an 18-month period and that some children changed placements as many as 12 times in that same period. See L. F. Stambaugh et al., *Psychotropic Medication Use by Children in Child Welfare,* OPRE Report #2012-33 (Washington, D.C.: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, 2012).

reasons, and the rationale and oversight for such medications were partially supported by documentation. In 3 of 9 infant cases, our experts were unable to discern whether the psychotropic medications were prescribed to infants for mental-health purposes or for some other medical reason, based on documentation reviewed.

In conclusion, early detection and treatment of mental-health conditions can improve a child's symptoms and reduce potentially detrimental effects, such as difficulties with relationships, dropping out of school, and involvement with the juvenile justice system. Despite the need for treatment, child mental-health advocates, providers, and researchers have expressed concern about the increase in prescribing of psychotropic medications for children because of limited information on the safety and efficacy of the medications being prescribed in the child population. Children in foster care are especially vulnerable because they more frequently have been subjected to traumatic experiences involving abuse or neglect and they may suffer from multiple, serious mental-health conditions. Our analysis of national survey data, state Medicaid data, and a sample of case files indicates that concerns raised by providers, advocates, and others about potentially inappropriate prescribing of psychotropic medications for children in foster care may be warranted. The federal government and state governments in our review recently have taken action to improve the oversight of psychotropic medication prescribing to foster care children, however, continued assessment and guidance is needed to protect this vulnerable population.

Chairman Reichert, Ranking Member Doggett, and Members of the Committee, this completes my prepared statement. I would be pleased to respond to any questions that you may have at this time.

Contacts and Acknowledgments

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