

PHARMACOTHERAPY PRACTICES AND GUIDELINES

- When a child or youth is being prescribed psychotropic medications, informed consent must be given. In establishing informed consent, information must be given to the child, youth, family (bio-parent, foster parent, or caregiver), and the caseworker/state-assigned decision maker about the treatment options (both medication and non-medication options), the risks/side effects and benefits of the medication, the targeted symptoms, and the course of treatment.

> Rationale: Part of the Institutes of Medicine definition of evidence-based practice includes the incorporation of the clinical experience of the prescriber as well as the values and beliefs of the child and family. There may be multiple means of addressing a psychiatric condition and the values of the child and family must be held primary in treatment decisions, unless it can be shown that those decisions would harm the child. This is the essence of informed consent. The role of the prescriber is to provide the information necessary for the decision-maker to come to a decision about the care of their child. These decisions are usually guided by adult caretakers depending on the age and developmental abilities of the child and existing laws or statutes. If the child is in state custody, it is the responsibility of the state to make these decisions, but the child/youth and parent should remain involved in the assessment and treatment of the mental health condition. Involving parents or other caretakers in the assessment and treatment process and decisions lays the ground work for familial support of continuing successful mental health treatment. Consistent with prior recommendations^{1,2}, efforts must be made to include the child as soon as possible through the assent process. This is particularly important for youth aging out of state custody who are required to act as the arbiter for their own care between the ages of 18 and 21, depending on state services.

- The child welfare agency must document (for example in the medical passport) the medications the child or youth is taking, the child's or youth's response to the medications, risks/side effects and benefits of the medications, and the timeframes for the expected response. This documentation will follow the child or youth throughout his or her stay in care.

1. Best Practices for Mental Health in Child Welfare: Screening, Assessment, and Treatment

Guidelines, Lisa Hunter Romanelli, John Landsverk, Jessica Mass Levitt, Laurel K. Leslie, Maia M. Hurley, Christopher Bellonci, Leonard T. Gries, Peter J. Pecora, Peter S. Jensen, and the Child Welfare Mental Health Best Practices Group. Published in *Journal of Child Welfare*, Issue 1, 2009, CWLA.

> Rationale: Continuity of care is a critical concern for children in the child welfare system. Due to lack of permanency in their lives, these children often receive care that lacks coordination and adequate integration. A single repository for medical information that can travel with the child between placements or is held in a single location (medical home model) despite where the child may be residing has been shown to improve outcomes for children in the child welfare system³. The establishment of an ongoing source of health care has been identified as a federal priority, along with ensuring that “all children with special health care needs will receive regular ongoing comprehensive care within a medical home.”⁴

- The prescriber should have ongoing communication with the child and caregiver to monitor treatment response and side-effects on a continuing basis, and discuss with the child adherence to medications and any medication changes in the context of an engaged collaborative, therapeutic relationship. Appropriate monitoring is essential for potential adverse outcomes including change in weight or metabolic parameters, cardiovascular symptoms, suicidality, or other outcomes as appropriate to the medications prescribed.

> Rationale: Psychotropic medications can be associated with significant side-effects that cannot be predicted in advance. In order to ensure that a child does not come to harm from a medication trial, frequent follow-up visits are necessary. Side-effects are most common in the initiation of a medication trial and close observation of the child/youth is particularly important during the first few months of medication treatment. Once it becomes clear the child is having a positive response to a medication trial without concerning side-effects and the child/youth, parent and child welfare case worker feel the benefits of the medication outweigh the side effects observed or potential risks, the child can be considered to be in a maintenance phase of treatment which may require less frequent contact.

- Recognized clinical rating scales or other measures should be used to quantify the response of the child’s target symptoms to treatment and the progress made toward treatment goals. In the initial phase of treatment (during the initial three months on a particular medication or regimen), visits should take place on at least a monthly basis, or more frequently if the child’s condition is unstable or worsening. For children whose response to medication has stabilized, follow-up after the initial three months should take place on a regular basis, at least quarterly or more frequent if clinically required. If the youth’s condition becomes unstable, contact with the prescriber should be available on an immediate basis. The agency should ensure consistent access to prescribed medication for youth.

> Rationale: Objective data helps making informed choices. Whenever possible, rating scales or objective data-gathering methods help to inform diagnoses, treatment recommendations and whether treatments are working. It also allows data to be collected from multiple informants (e.g. teachers, caretakers, therapists). The more accurate the data, the better the outcome.

- Caseworkers will know about or have training on:
 - Child and adolescent development
 - Neuro-developmental effects of prenatal substance exposure
 - Common mental health disorders in the child welfare population
 - Effective treatment options for these mental health disorders

> Rationale: Children in foster care have significant, and often co-occurring, developmental, behavioral, and mental health problems.⁵ Estimates of mental health problems for children in foster care range from 23% to 80%. Published rates of developmental delay for young children in foster care are reported to be as high as 60% (compared to 4% - 10% in the general population), and rates of clinically significant behavioral problems in children under the age of 6 are reported as high as 40% (compared to 3% to 6% in the general population).^{5-8 9} Children in a national foster care sample were 3 to 10 times more likely to have a mental health problem compared with children on AFDC. Children in foster care were also more likely to suffer from depression (5.9% vs 1.1%), anxiety disorder (2.5% vs 0.8%), ADHD (14.7% vs 3.9%), conduct disorder (4.5% vs 0.6%), bipolar disorder (1.0% vs 0.1%), and oppositional defiant disorder (9.4% vs 1.9%) than children eligible through AFDC. When age, sex, race, type of eligibility, and county of residence were controlled for, differences in diagnosis rates were at least as large and often even larger¹⁰. Prevalence of mental disorders among youths enrolled in foster care in a mid-Atlantic state (57%) was twice that of youths receiving Supplemental Security Income (SSI) and nearly 15 times that of other youths receiving other types of public aid (4%). The most prevalent disorders were ADHD, depression, and developmental disorders.¹¹

For caseworkers to act in the role of ‘loco parentis’ for children in state custody, they must have a basic knowledge of normal development, the impact of parental substance use on development, and common mental health disorders. In addition, caseworkers need to be aware of evidence-based treatments for mental health disorders that incorporate an understanding of the unique histories and vulnerabilities of children in state custody (see, for example, the California Evidence-based Clearinghouse for Child Welfare, <http://www.cachildwelfareclearinghouse.org/>). Caseworkers represent the front-line of intervention and, although not a substitute for formal mental health screening, they must serve as advocates to ensure children receive the mental health treatment they require. In order to achieve this goal they must be able to identify when a child’s behavior or development is atypical and in need of further assessment and/or treatment and assure that child is accessing efficacious treatments.

- Youth and families should be provided ongoing information on the diagnosed mental health disorder, effective treatment options, and managing life with the condition including:
 - What to expect in the future
 - How severe the condition is
 - Can the youth not take medication in the future
 - What can be done instead of medication
 - How to access help in the future

> Rationale: The role of the prescriber is as a consultant to the child/youth, parents, caretakers and child welfare staff. It requires educating all involved parties in order for those parties to make the best possible decision with the available information. It is an evolutionary process, as more information becomes available our understanding of the underlying condition and its treatment may change. Ultimately, the child and their caretakers will be responsible for implementing treatment and effecting change in their lives. The prescriber's role is to act as a catalyst towards that growth.

- The agency should ensure transition planning in advance of youth leaving care that includes identification of providers and source of payment for treatment.

> Rationale: If the youth has been given adequate information about their mental health condition and provided a role in the decision-making regarding their treatment, it can be expected they will make safe and appropriate decisions about continuing their therapies (both medication and non-medication treatments). For youth transitioning out of care or aging out of the child welfare system it is imperative that sufficient information and resources be provided so they can serve as their own case managers and can continue to access effective treatments.

- The child welfare agency should encourage, support, and monitor the mental health needs and access to psychotropic medications and other mental health services for birth families.

> Rationale: Depressed parents were found to be 3.45 times more likely to initiate physical abuse than non-depressed counterparts. Substance abuse was associated with both physical abuse and neglect.¹² Forty percent of parents who abused children and 56% who were neglectful were substance abusers compared to 16% of non-abusive and 17% of parents who were not neglectful.¹³ In a national sample of children involved with child welfare 40% of caregivers received a diagnosis of depression based on research diagnostic criteria, a rate which exceeds the rate of depression in the general population (16.6%).¹⁴ Of children in foster care in 2006, 49% had a case goal of reunification. Of those exiting care in 2006, 53% were reunified with biological parents or primary caretaker.¹⁵ Data from AFCARS and the Multistate Foster Care Data Archive (administrative data from 12 states managed by Chapin Hall) indicate that nearly 30% of children reunified with parents re-enter the foster care system within 10 years.^{15,16} Successful reunification of a child with their parent requires that parents receive treatment for their mental health and substance abuse disorders.

- The agency should periodically conduct reviews of patterns of psychotropic medication use within its caseload, on an aggregate- and provider-specific basis, and take necessary action in response to findings of such reviews.

> Rationale: The few studies available show rates of medication use for children in child welfare ranging from 13-37%¹⁷⁻²³, compared with approximately 4% in youth in the general population^{24,25}. One national sample of children involved with child welfare found 13.5% of children were taking psychotropic medications.²² In Los Angeles County,

16% of youth ages 6-12 living in out of home placements were taking psychotropic medications. Stimulants were the most common class of medication taken (56%).²³ The prevalence of youth in foster care taking psychotropic medications was 34.7% in a southwestern US state. In 2004, 41.3% of these children that had been given psychotropic medication received 3 or more different classes of drugs and 16% received four or more classes. Most commonly prescribed medications to this population were antidepressants (56.8%), ADHD drugs (55.9%) and antipsychotics (53.2%).²¹ Although there is wide variability in the prescribing rates of psychotropic medications for children in the child welfare system, there does appear to be a significantly higher rate of psychotropic medication use for children in state custody compared to non-custodial children receiving Medicaid services or the general population of youth. In order to ensure that the use of psychotropic medication is both safe and appropriate states should monitor the use of these medications and be required to report the data to a national database.

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