2013 Report to the Pennsylvania State Roundtable

To Each What They Need: Monitoring and Oversight of Psychotropic Medication for Dependent Children

Psychotropic Medication Workgroup

Chairpersons:

Honorable Kathryn Hens-Greco
Court of Common Pleas of Allegheny County

David Schwille, Administrator
Venango County Human Services

Psychotropic Medication Workgroup Members

Chairpersons

Honorable Kathryn Hens-Greco
Judge
Court of Common Pleas of
Allegheny County

David Schwille
Administrator
Department of Human Services
Venango County

Members

Ivonne Acrich, MD
Psychiatrist
Department of Public Welfare
Office of Mental Health and Substance Abuse Services

Dale Adair, MD
Chief Medical Officer
Department of Public Welfare
Office of Mental Health and Substance Abuse Services

Mary Ann Albaugh, MD
Child and Adolescent Psychologist
President
Western PA Psychiatric Society Chapter

Laurie Ayler, LSW
Outcomes in Behavioral Health Clinical Coordinator
Support Center for Child Advocates

Chris Bastress
Assessment Supervisor
Lycoming County Children and Youth Services

Darlene Black
Human Service Program Specialist Supervisor
Department of Public Welfare
Office of Childen, Youth and Families

Christine Breakstone
Parent Representative
Venango County

Melanie S. Brodhead
Quality Assurance Program Specialist
Adams County Children & Youth Services

Dana Byrd
Managed Care Social Worker
Bucks County Children and Youth Services

Brian Davis
Curriculum and Instructional Specialist
The PA Child Welfare Resource Center

Sharon Dunn, MSW
Program Specialist
Lehigh County Children and Youth Services

Gail A. Edelsohn, MD, MSPH
Senior Medical Director, Quality
Community Care Behavioral Health Organization

Fran Gutterman
Senior Director
Casey Family Programs

Gloria Hamm, RN, MS
Registered Nurse (retired)
County Commissioner (former)
Lehigh County

Gordon Hodas, M.D.
Child Psychiatric Consultant
Department of Public Welfare
Office of Mental Health and Substance Abuse Services

Michelle C. Kahan, Esq.
Juvenile Dependency Master
York County

David Kelley
Chief Medical Officer
Department of Public Welfare
Office of Medical Assistance Programs

Garry Krentz
Foster Parent Representative
PA Foster Parent Association

Andrea Matsko, MSS
Program Specialist
Bucks County Children and Youth Services

Andrea Meixel, BSW
Regional Technical Assistant
Statewide Adoption and Permanency Network

Roxanne Michels
Case Manager
Integrated Family Services
Lehigh County

Dorothy Miller, JD, MPH
Research Scientist
PolicyLab
The Children's Hospital of Philadelphia

Ron Phillips
Child Advocacy Specialist
KidsVoice

Manuel D. Reich, DO
Associate Medical Director
Value Behavioral Health of Pennsylvania

James Schuster, MD, MBA
Chief Medical Officer
Community Care Behavioral Health Organization

Alyssa Snyder, MBA
Manager of Children's Behavioral Health
Bucks County Behavioral Health

Scott Talley
Division Chief of Operations
Department of Public Welfare
Office of Mental Health and Substance Abuse Services

Patricia Valentine
Executive Deputy Director for Integrated Program Services
Department of Human Services
Allegheny County

Greta Weiss
Youth Ambassador
Child Welfare Resource Center

Demara M. Williams
Youth Representative
Lehigh Co. Local Children's Roundtable
VYH Peer Mentor/Resident Advisor
Youth Advisory Board

Sarah Zlotnik
Senior Strategist
PolicyLab
The Children's Hospital of Philadelphia

Honored Guest

Kathleen Noonan, JD
PolicyLab
The Children's Hospital of Philadelphia

Administrative Office of Pennsylvania Courts/Office of Children and Families in the Courts Staff

Lynne Napoleon
Judicial Programs Analyst

Elke Moyer
Administrative Associate & Graphic Designer

Sandy Moore
Administrator

To Each What They Need:
Monitoring and Oversight of Psychotropic Medication for Dependent Children

A Report to the State Roundtable of Pennsylvania

"The mission of the psychotropic medication workgroup is to recommend a system of collaborative oversight focusing on children and youth involved in the dependency system to ensure that those with mental and behavioral health needs have a plan for appropriate and effective intervention to achieve healthy development."

Background:

In 2011, through the roundtable system utilized by the Commonwealth of Pennsylvania, leaders in the child welfare system began to talk about their concerns with the usage of psychotropic medication for children in the dependency system. Along with a national focus on the disturbing trend of increased medication for children in the child welfare system, Pennsylvania leaders felt it was time to explore the usage of psychotropic medication with its dependent children and its impact on their health and well-being. As such, the Pennsylvania State Roundtable commissioned a workgroup with the goal of surveying both national and state concerns and identifying measures that are underway to ensure the appropriate monitoring and oversight of psychotropic medication.

The Psychotropic Medication Workgroup, a multi-disciplinary committee under the leadership of the Honorable Kathryn Hens Greco, Court of Common Pleas of Allegheny County and David Schwille, Administrator, Department of Human Services of Venango County, convened in August 2011. Meeting seven times prior to the 2012 State Roundtable, the group was able to study several national reports and Pennsylvania reports on the subject of psychotropic medication. They explored protocols from a number of states that have addressed this issue, consulted with medical experts from various systems within Pennsylvania, held focus groups to get input from the parents and youth in Pennsylvania, and researched best practice recommendations from the American Academy of Child and Adolescent Psychiatry and the American Academy of Pediatrics as well as the American Bar Association's Center on Children and the Law.

Following the State Roundtable in 2012, the workgroup developed four subcommittees that met independently to accomplish the tasks recommended to the State Roundtable. These subcommittees included those working on the local children's roundtable discussion guide, the psychotropic medication information card, the website resources, and policy. These subcommittees met at various times throughout the year. Additionally, the full Psychotropic Medication Workgroup met on several occasions to provide feedback on subcommittees' work, to explore issues related to data and national trends, and to develop a set of well-informed recommendations for the 2013 State Roundtable.

Update on work of the Psychotropic Medication Workgroup

The Psychotropic Medication Workgroup made a number of recommendations to the State Roundtable in May 2012. While beginning its tasks to address these recommendations, the Workgroup spent time exploring the issue of trauma and the intersection of trauma with psychotropic medication. It quickly became clear to the group that one could not adequately address the oversight and monitoring of psychotropic medication for dependent children without first assessing for issues related to trauma and, if present, providing intervention for those issues. While recognizing that not every child that enters the dependency system has had a traumatic experience, many do. Many of these "traumatized" children go unidentified and untreated. For those children, the concern becomes that medication may be prescribed to treat symptomatic behavior but may not address the underlying issue of trauma. As such, the use of psychotropic medication may continue longer than might be necessary otherwise. With this realization, the need to become a trauma sensitive system provided the lens through which the group viewed their work and subsequent recommendations.

Recommendation 1: Collaboratively develop guidelines and/or policy regarding oversight and monitoring of psychotropic medication for the dependent children in Pennsylvania.

A policy subcommittee formed that included representatives from the court, Office of Children and Youth, Office of Mental Health and Substance Abuse Services, Office of Medical Assistance Programs, county Children and Youth Services, psychiatrists, psychologists, managed care providers, service providers, foster parents, parents and youth. Through initial exploration of policies and practices already in place in Pennsylvania, it became clear that a unified approach would best suit the needs of dependent children. Isolated policies seemed to be in place within the separate service system structures, with multiple policies occasionally occurring within a service system as in the case of Medical Assistance Programs where different policies exist for fee-for-service and managed care. Developing basic guidelines that could be put in place regardless of funding stream appeared to be the most beneficial solution to oversight. Because the dependent child population is supported through multiple funding streams, a unified policy would provide consistent markers that would enable greater accuracy in monitoring psychotropic medication usage.

The subcommittee focused on several key areas for the development of policy: informed consent and assent, appropriate screening, assessment and treatment, and development of a statewide monitoring system of "red flags." Different members of the subcommittee brought their expertise and best thinking on the key areas to the full subcommittee for discussion and consideration. A summary of work to date is as follows:

Informed Consent/Assent

- While it is the obligation of the treating professional to engage the client in the ongoing process of informed consent, it was determined that the dependency system needs to provide oversight to ensure informed consent is happening. In essence, the dependency system must ensure that the children for whom they are responsible are actually providing informed consent.
- Child welfare needs a consistent way to document that dependent children are engaged in an ongoing process of informed consent with the physician prescribing psychotropic medication and provide that information to others who are involved in the child's case.

Screening/Assessment/Treatment

- While oversight and monitoring of psychotropic medication was the primary focus of the workgroup, the group quickly identified that without attention to issues of trauma, oversight and monitoring becomes incomplete. Early intervention of trauma-specific mental health issues can have a resultant effect on usage of psychopharmacological interventions. As such, screening for the trauma to assist in early referral to appropriate trauma-specific mental health services is paramount.
- Various screening and assessment tools for trauma were explored to develop an understanding of those that were widely available and accessible for usage by professionals of varying backgrounds. Within Pennsylvania's child welfare system no standard protocol for early screening of trauma is currently being used.
- *The Child Welfare Trauma Referral Tool* (Attachment A) was selected as the tool that is most accessible and allows for quick screening of potential trauma with an easy to follow decision tree to make a trauma-informed mental health referral, a general mental health referral, a referral for immediate stabilization in the case of a child who is at risk for serious injury or to do nothing if no mental health referral is needed. The tool utilizes record review and key interviews to collect information regarding stress reactions, trauma/loss history, attachments, current functioning, and behavior requiring immediate stabilization.
- While tools and support are available, counties will need to assess and develop their own capacity for trauma-informed mental health care to meet the needs of the dependent children in their community. The *Psychotropic Medication Discussion Guide for Local Children's Roundtables* (Attachment B) was created to facilitate this local conversation.

Statewide "Red Flag" Monitoring System

- Prior authorizations for psychotropic medications already in place in Pennsylvania were explored, including those from fee-for-service and those in place within managed care organizations.
- There was consensus within the subcommittee that the dependent children of Pennsylvania would be served best with consistent prior-authorization and monitoring despite the funding stream in which they participated.
- The policy subcommittee met with representatives from Pennsylvania's physical and mental health managed care organizations to discuss monitoring systems and "red flags" as well as plans moving forward.
- Members of the physical and behavioral health managed care organizations selected two representatives to join the policy subcommittee. All agreed to work towards a monitoring system with the same "red flags" for all organizations.
- Subcommittee members from the PolicyLab at The Children's Hospital of Philadelphia provided a national view of "red flags" adopted in other states and provided guidance on data-informed planning for such.

While the work of the subcommittee continues, development of large, statewide and multi-system monitoring is a monumental task and involves many people working in tandem to secure a functional and realistic solution. As such, the subcommittee recommends that the continuation of this work move to a statewide workgroup called the Health Care Workgroup headed by the Department of Public Welfare and co-chaired by David Kelley, MD, MPA, Chief Medical Officer, Office of Medical Assistance Programs and Cindy Christian, MD, Director, Safe Place: Center for Child Protection and Health at The Children's Hospital of Philadelphia. This workgroup has the breath and the scope necessary to effect large-scale policy development.

Recommendation 2: Explore the possibility of providing incentives to providers who attain positive outcomes for children in the dependency system relating to mental and behavioral health treatment, including psychotropic medication.

The Psychotropic Medication Workgroup hoped to devise a system similar to that used in Tennessee where incentives motivated a wide range of providers to attain positive outcomes for dependent children. The thought being that providers who do quality work will be rewarded and it would be less advantageous to keep a child in a higher level treatment without true need just to have the capacity of the program met. The Workgroup believed this would have a positive impact on congregate care by keeping children from languishing in programs that are not effective or encouraging discharge when children have received the maximum effectiveness of the program. After considerable discussion, it was determined that moving forward with this recommendation was premature. Without a standardized set of "red flags" from which to monitor psychotropic medication usage and concurrent psychosocial treatment

interventions, developing a system of incentives would likely be fraught with complications. This item has been placed on hold until such a time that an infrastructure exists that would support its success.

Recommendation 3: Facilitate the development of training on oversight of psychotropic medication to support what is expected of all partners in the child welfare system.

While the Workgroup proceeded with diligence, it was unable to complete the tasks that would be necessary to move forward with the development of training to support the oversight and monitoring of psychotropic medication for dependent children. When Pennsylvania decided to monitor psychotropic medication from a multi-system approach, the time needed to bring together the various system stakeholders slowed the work of curriculum development. It is anticipated that work can begin on the supportive curriculum sometime in early 2014. In the meantime, the Psychotropic Medication Workgroup has created an information card, the *Psychotropic Medication Key Questions Information Card* (Attachment C), intended to provide guidance to judges, legal representatives, caseworkers and others in the dependency system as they provide ongoing oversight and monitoring of the medication and other forms of treatment received by dependent children.

Recommendation 4: Collaborate with the Children's Hospital of Philadelphia's PolicyLab as supported by Casey Family Programs to provide counties with data specific to the usage of psychotropic medication with their child welfare population. Provide counties a guide to assist them in discussing their county-specific data and protocols around psychotropic medication for children in the child welfare system.

PolicyLab of The Children's Hospital of Philadelphia, with the generous support of Casey Family Programs, is completing a state-level data analysis on psychotropic medication use for dependent children in Pennsylvania. As a start, the project team shared with the Workgroup rates of antipsychotic medication use and polypharmacy from Pennsylvania's Medicaid data from 2002-2009. From 2002 to 2009, the rate of antipsychotic medication use rose from 5.68% of children in foster care in 2002 to a peak of 7.13% in 2008, dropping to 6.68% in 2009. For polypharmacy, the use of three or more classes of psychotropic medications, the rate decreased from a high in 2002 of 3.03% of children in foster care to 2.5% in 2009. Pennsylvania trends appear consistent with national trend data. While these trends are a positive development, and appear to reflect increasing efforts towards monitoring and oversight, strengthening of these policies is necessary to ensure children in foster care receive appropriate mental health services in alignment with their mental health needs.

A current analysis is underway to look at young children (aged 3-5 years), a population of particular concern. Preliminary analysis shows that Pennsylvania's children in foster care (including formal kinship care) receive psychotropic medication at higher rates than

other children receiving Medicaid, they are three times more likely to receive antipsychotic medication, and are subject to polypharmacy at two and one-half times the rate of other children on Medicaid.

Additionally, a regional analysis is also underway. It was hoped that the regional analysis would be completed at an earlier date so that counties could be provided with their data together with the *Psychotropic Medication Discussion Guide for Local Children's Roundtables* which might inform their conversations. Unfortunately, difficulties arose in the exchange of Medicaid data from the Office of Medical Assistance Programs to The Children's Hospital of Philadelphia PolicyLab and the analysis was delayed. Now that the data has been received, the analysis is being developed in such a way that Pennsylvania will have the capacity to duplicate PolicyLab's analyses in the future to track outcomes and identify ongoing concerns.

Even without county-specific data, the Workgroup believed a tool to facilitate local conversations and examination of this issue could be helpful. As such, the *Psychotropic Medication Discussion Guide for Local Children's Roundtables*, created by the Psychotropic Medication Workgroup. This guide is a tool for local children's roundtables to use to facilitate a discussion of beliefs, practices, and needs related to psychotropic medication oversight and monitoring including an assessment of available trauma-informed service providers and trauma-specific interventions within the county. The guide was developed to be used by either the local children's roundtable or a subcommittee of a local children's roundtable who is tasked with making recommendations to the larger group.

Recommendation 5: Develop a psychotropic medication resource section on the Office of Children and Families in the Courts website while exploring the possibility of a more comprehensive, multi-functional and multi-disciplinary website.

Presently, a section of the Office of Children and Families in the Court's website is designated to the Psychotropic Medication Workgroup. A list of links and documents providing a ready-reference for people working in the dependency system can be found on the site. Not only will distributed information, such as the *Psychotropic Medication Key Questions Information Card* and *Psychotropic Medication Discussion Guide for Local Children's Roundtables*, be located on the site but current government reports, reference guides and links to websites with information about psychotropic medication, trauma and trauma-informed care and services will be located there as well. Hopefully, by accumulating information and resources in one location, anyone wishing to do further research about best practices might have a place to begin their research.

Conclusion

Providing quality oversight and monitoring of psychotropic medication for children in the dependency system is a complex task. It includes the consideration of elements of trauma and well-being as well as those of assessment, diagnosis and treatment for mental health concerns. To say it is enough to make sure that dependent children are taking the medication they need and only what is needed is to shortchange the scope of the oversight. Viewing children in the dependency system through a lens that incorporates the developmental, contextual and historical aspects of children's lives creates a richer, more robust picture that likely leads to a better-informed process of decision making for the child, including those decisions to use a psychopharmacological approach to treatment in conjunction with effective psychosocial interventions.

Recommendations:

The Psychotropic Medication Workgroup requests the authorization of the State Roundtable to continue to meet and work on issues pertaining to the oversight and monitoring of psychotropic medication for children in the dependency system. *In addition, the Workgroup respectfully submits to the Pennsylvania State Roundtable the following recommendations:*

1. Approval and distribution of the *Psychotropic Medication Discussion Guide for Local Children's Roundtables* and the *Psychotropic Medication Key Questions Information Card*.
2. Permission given for the work of the policy subcommittee to be incorporated into the larger Department of Public Welfare Health Care Workgroup where it will have the impact that it needs to effectuate multi-systemic change.
3. Electronic distribution of the American Bar Association's guide, "Psychotropic Medication and Children in Foster Care: Tips for Advocates and Judges" to the Leadership Roundtable Distribution List, Hearing Officer Distribution List as well as those for legal representatives in dependency hearings. http://www.americanbar.org/content/dam/aba/administrative/child_law/PsychMed.authcheckdam.pdf
4. Distribution of the Administration for Children and Family Children's Bureau guide, "Making Healthy Choices: A Guide on Psychotropic Medications for Youth in Foster Care." http://www.nrcyd.ou.edu/publication-db/documents/psychmedyouthguide.pdf
5. Development of a template of information about psychotropic medication and other mental health treatments to be included as part of a report to the court and forward to Bench Book Committee for consideration of inclusion in the Bench Book.
6. Development of a curriculum regarding the oversight and monitoring of psychotropic medication. The Psychotropic Medication Workgroup would work

closely with the Child Welfare Resource Center, becoming the Quality Assurance Committee in the development of that curriculum.

7. Adopt the *Child Welfare Trauma Referral Tool* (as developed by the National Child Traumatic Stress Network) as a front-end screening tool for the early identification of the need for trauma specific mental health referral. The tool, along with the companion guide, "Child Welfare Trauma Training Toolkit" be provided to each county's local children's roundtable for protocol development and implementation.
8. Ask the Bench Book Committee to explore positive and progressive activities that are happening around the state to create trauma-informed courtrooms and facilitate the distribution of best practices around this important issue.
9. Survey counties regarding their past and present practice of oversight and monitoring of psychotropic medication to ascertain if the distributed materials have made a positive impact and areas for further consideration and development.

Amended and Approved by the 2013 Pennsylvania State Roundtable:

1. Approval and distribution of the Psychotropic Medication Discussion Guide for Local Children's Roundtables and the Psychotropic Medication Key Questions Information Card.
2. Permission given for the work of the policy subcommittee to be incorporated into the larger Department of Public Welfare Health Care Workgroup where it will have the impact that it needs to effectuate multi-systemic change.
3. Electronic distribution of the American Bar Association's guide, "Psychotropic Medication and Children in Foster Care: Tips for Advocates and Judges" to the Leadership Roundtable Distribution List, Hearing Officer Distribution List as well as those for legal representatives in dependency hearings. http://www.americanbar.org/content/dam/aba/administrative/child_law/PsychMed.authcheckdam.pdf **Workgroup will amend page # 5 of the guide prior to distribution.**
4. Distribution of the Administration for Children and Family Children's Bureau guide, "Making Healthy Choices: A Guide on Psychotropic Medications for Youth in Foster Care." http://www.nrcyd.ou.edu/publication-db/documents/psychmedyouthguide.pdf
5. Development of a template of information about psychotropic medication and other mental health treatments to be included as part of a report to the court and forward to Bench Book Committee for consideration of inclusion in the Bench Book.

6. Development of a curriculum regarding the oversight and monitoring of psychotropic medication. The Psychotropic Medication Workgroup would work closely with the Child Welfare Resource Center, becoming the Quality Assurance Committee in the development of that curriculum.
7. **Recommend** the Child Welfare Trauma Referral Tool (as developed by the National Child Traumatic Stress Network) as a front-end screening tool for the early identification of the need for trauma specific mental health referral. The tool, along with the companion guide, "Child Welfare Trauma Training Toolkit" be provided to each county's local children's roundtable for protocol development and implementation.
8. Ask the Bench Book Committee to explore positive and progressive activities that are happening around the state to create trauma-informed courtrooms and facilitate the distribution of best practices around this important issue.
9. Survey counties regarding their past and present practice of oversight and monitoring of psychotropic medication to ascertain if the distributed materials have made a positive impact and areas for further consideration and development.

Module 4, Activity 4F; Module 4, Activity 4G

Child Welfare Trauma Referral Tool

This measure is designed to help child welfare workers make more trauma-informed decisions about the need for referral to trauma-specific and general mental health services. It is to be completed by the child welfare worker through record review and key informants (i.e., natural parent, foster parent, child therapist, school-aged children or adolescents if appropriate, and other significant individuals in the child's life).

Section A allows the child welfare worker to document history of exposure to a variety of types of trauma and indicate the age range over which the child experienced each trauma. Section B allows the child welfare worker to document the severity of the child's traumatic stress reactions. Section C allows the child welfare worker to document attachment problems. Section D allows the child welfare worker to document behaviors requiring immediate stabilization. Section E allows the child welfare worker to document the severity of the child's other reactions/behaviors/functioning. Section F provides strategies for making recommendations to general or trauma-specific mental health services by linking the child's experiences to their reactions.

Form Completed by (Name/Title/ID Code): _____ Date: _____

Child's Name: _____ Age: _____ Number of Months in Current Placement: _____

Reason for Current Evaluation (check all that apply):

☐ Baseline Assessment: New client ☐ New Trauma Reported ☐ Problematic Reactions/Behaviors Reported

☐ Change in Placement (Specify): _____ ☐ Other (Specify): _____

Instructions: Please fill out Sections A through E below by checking the box that corresponds to your answer:

- If there is absolutely NO information about the trauma factor in the vignette, you must answer **UNKNOWN**.
- If there is SOME information about the trauma factor in the vignette, you have three choices:
  - **YES**, if the information suggests that this trauma factor likely occurred,
  - **NO**, if the information suggests this trauma factor did not occur,
  - **SUSPECTED**, if the information suggests that this trauma factor could have occurred but more information is needed for a decision.

A. Trauma/Loss Exposure History

Trauma Type (Definitions attached)					Age(s) Experienced (Check each box as appropriate – example sexual abuse from ages 6–9 would check 6, 7, 8, and 9)																	
	Yes	Suspected	No	Unknown	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
1. Sexual Abuse or Assault/Rape	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2. Physical Abuse or Assault	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3. Emotional Abuse/Psychological Maltreatment	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4. Neglect	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5. Serious Accident or Illness/Medical Procedure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6. Witness to Domestic Violence	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7. Victim/Witness to Community Violence	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8. Victim/Witness to School Violence	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9. Natural or Manmade Disasters	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10. Forced Displacement	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
11. War/Terrorism/Political Violence	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
12. Victim/Witness to Extreme Personal/ Interpersonal Violence	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
13. Traumatic Grief/Separation (does not include placement in foster care)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
14. Systems-Induced Trauma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

B. Current Traumatic Stress Reactions (Answer questions B1–B4 in reference to the CURRENT situation only.)

	Yes	Suspected	No	Unknown	Definition (Check Yes if child presents with any of the descriptors listed below)
1. Re-experiencing	☐	☐	☐	☐	These symptoms consist of difficulties with intrusive memories or reminders of traumatic events, including nightmares, flashbacks, intense reliving of the events, and repetitive play with themes of specific traumatic experiences. Also included is pronounced reactivity to trauma or loss reminders. These symptoms are part of the DSM-IV criteria for PTSD.
2. Avoidance	☐	☐	☐	☐	These symptoms include efforts to avoid stimuli associated with traumatic experiences. The child may avoid certain places or people, or avoid discussing the specifics of the trauma. These symptoms are part of the DSM-IV criteria for PTSD.
3. Numbing	☐	☐	☐	☐	These symptoms include numbing responses that are part of the DSM-IV criteria for PTSD. These responses were not present before the trauma. Numbing symptoms include feelings of detachment or estrangement from others, restricted range of emotion (e.g., unable to have loving feelings), feeling out of sync with others, or having a sense of a foreshortened future.
4. Arousal	☐	☐	☐	☐	These symptoms consist of difficulties with hypervigilance (an exaggerated awareness of potential dangers), difficulty concentrating, exaggerated startle reactions, difficulties falling or staying asleep, and irritability or outbursts of anger. Children with these symptoms often seem distractible, impulsive and inattentive, leading to a common misdiagnosis of ADHD.

C. Attachment

	Yes	Suspected	No	Unknown	Definition (Check Yes if child presents with any of the descriptors listed below)
1. Attachment Difficulties	☐	☐	☐	☐	This category refers to a child's difficulty forming or maintaining relationships with significant parental or caregiver figures. It relates to the child's sense of security and trust in interacting with others. Often children with attachment difficulties interact with new acquaintances in unusual ways. They may bond too quickly (e.g., hugging strangers and climbing on their laps), or fail to engage in appropriate ways (e.g., avoid eye contact and fail to engage in appropriate conversations/ interactions).

D. Behaviors Requiring Immediate Stabilization

	Yes	Suspected	No	Unknown
1. Suicidal Intent	☐	☐	☐	☐
2. Active Substance Abuse	☐	☐	☐	☐
3. Eating Disorder	☐	☐	☐	☐
4. Serious Sleep Disturbance	☐	☐	☐	☐

E. Current Reactions/Behaviors/Functioning (Answer questions E1–E12 in reference to the current situation only)

	Does this interfere with child's daily functioning at home, in school or in the community?				How to Recognize Problem Behaviors (Check Yes if child presents with any of the descriptors listed below)
Regulation of Emotion	Yes	Suspected	No	Unknown	Definition (Check Yes if child presents with any of the descriptors listed below)
1. Anxiety	☐	☐	☐	☐	Anxious children often appear tense or uptight. Worries may interfere with activities and they may seek reassurance from others or be clingy. These children may be quiet, compliant and eager to please, so they may be overlooked. Anxious children may report phobias, panic symptoms, and report physical complaints, startle easily, or have repetitive unwanted thoughts or actions.
2. Depression	☐	☐	☐	☐	Depressed children may appear tearful/sad, show decreased interest in previous activities, have difficulty concentrating, or display irritability, They may present with depressed mood, social withdrawal, sleep disturbances, weight/eating disturbances, loss of motivation, verbal aggression, sullenness, grouchiness, hopelessness, or negativity. They may have frequent complaints of physical problems.
3. Affect Dysregulation	☐	☐	☐	☐	Children with affect dysregulation may have difficulty expressing specific feelings, whether positive or negative, and may have trouble fully engaging in activities. They may have problems modulating or expressing emotions, experience intense fear or helplessness, or have difficulties regulating sleep/wake cycle.
4. Dissociation	☐	☐	☐	☐	Children experiencing dissociation may daydream frequently. They may seem to be spacing out and be emotionally detached or numb. They are often forgetful and sometimes they experience rapid changes in personality often associated with traumatic experiences.
5. Somatization	☐	☐	☐	☐	Somatization is characterized by recurrent physical complaints without apparent physical cause. Children may report stomachaches or headaches, or on the more serious end of the spectrum, they may report blindness, pseudoseizures, or paralysis.

6. Attention/Concentration	☐	☐	☐	☐	Children with problems with attention, concentration and task completion often have difficulty completing schoolwork or may have difficulty forming strong peer relationships.
Regulation of Behavior	Yes	Suspected	No	Unknown	Definition (Includes risky behaviors) (Check Yes if child presents with any of the descriptors listed below)
7. Suicidal Behavior	☐	☐	☐	☐	Includes both superficial and more serious actions with potentially life-threatening consequences. Examples include overdosing, deliberately crashing a car, or slashing wrists.
8. Self-Harm	☐	☐	☐	☐	When someone deliberately harms him or herself. Includes cutting behaviors, punching oneself, pulling out hair or eyelashes, picking skin causing sores, burning, inhaling or overdosing on medications.
9. Regression	☐	☐	☐	☐	Child ceases using previously adaptive behaviors. Child may begin wetting or soiling themselves after they had been potty trained, and may begin using baby talk or refusing to sleep alone when these skills were previously mastered.
10. Impulsivity	☐	☐	☐	☐	Acting or speaking without first thinking of the consequences.
11. Oppositional Behaviors	☐	☐	☐	☐	Defined by negativistic, hostile and defiant behaviors. Child may lose temper frequently, argue with adults, and refuse to comply with adult rules. Child may deliberately annoy people and blame others for mistakes or misbehaviors.
12. Conduct Problems	☐	☐	☐	☐	Defined by a variety of different conduct problems. Child may be physically or verbally aggressive to other people or animals. Children with conduct problems may destroy property, steal, break the law, or start fires. They may run away from home or act in a sexually promiscuous or aggressive fashion.

F. Given the information provided in the vignette, what is the appropriate next step? (Please circle one answer.)

a. Trauma-informed mental health referral

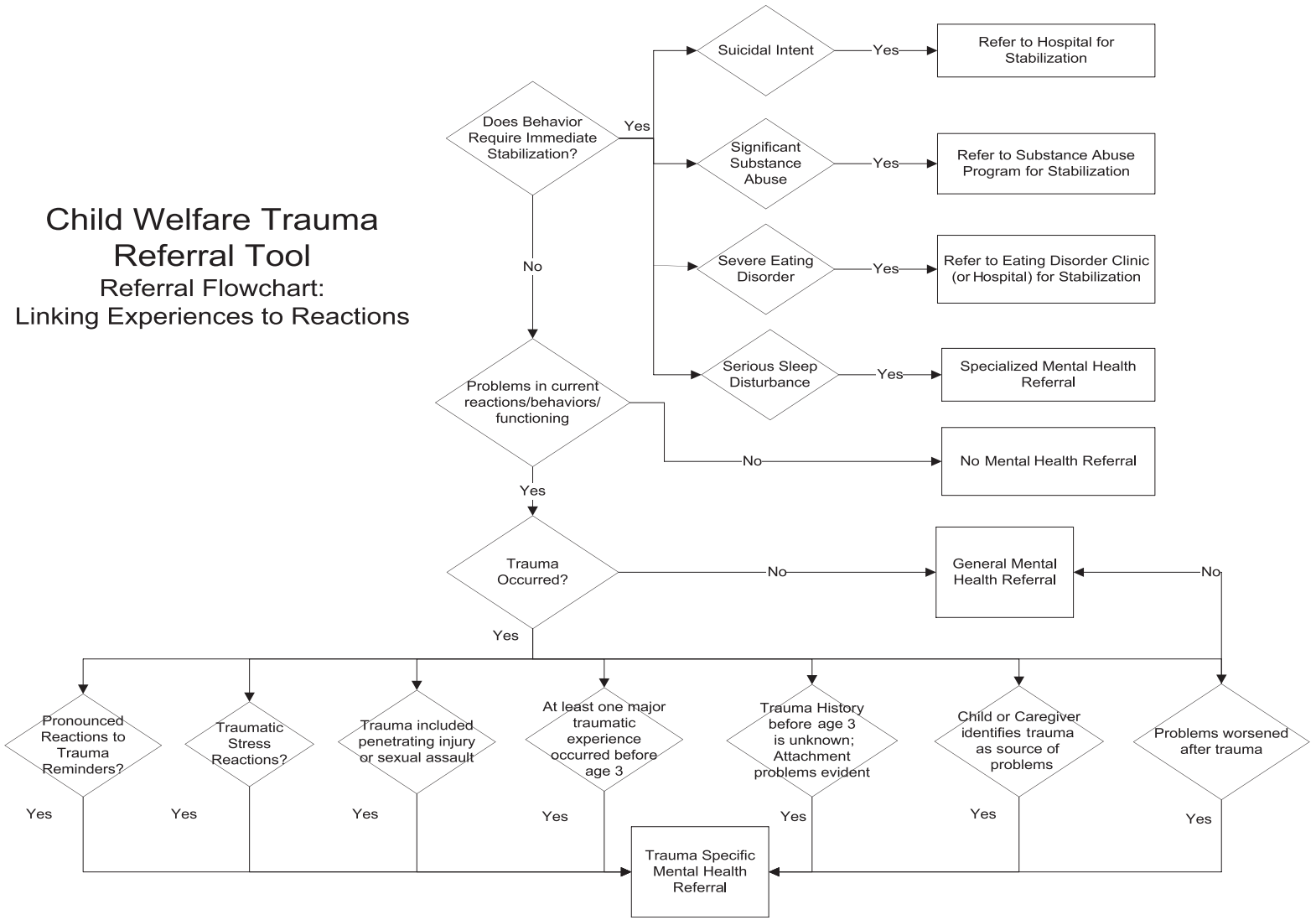
b. General mental health referral

c. Immediate stabilization mental health referral

d. No mental health referral

Child Welfare Trauma Referral Tool

Referral Flowchart: Linking Experiences to Reactions



PSYCHOTROPIC MEDICATION DISCUSSION GUIDE
for Local Children's Roundtables

Appropriate Role of Psychotropic Medication for Youth in Child Welfare

Psychotropic medication involves medications used to treat specific psychiatric disorders and mental health-related symptoms and behaviors that interfere with effective functioning for individuals.

- For children in foster care, such disorders and behaviors may compromise their permanency, as well as cause distress and interfere with normal development.
- Children in foster care are more likely to be prescribed psychotropic medications as they grow older, with 3.6 percent of two to five year-olds taking psychotropic medications at any given time. This increases to 16 .4 percent of six to 11 year-olds and 21.6 percent of twelve to sixteen year-olds. The likelihood that a child will be prescribed multiple psychotropic medications also increases with age.[1] Males in foster care are more likely to be receiving psychotropic medications (19.6%) than their female counterparts (7.7 %). [2]
- There is rising concern about the appropriate use (both over- and under-use) of psychotropic medications for youth in foster care. [3]

What is your view of how the use of psychotropic medications impacts dependent children and youth that you come in contact with in your county, across all systems, medically, behaviorally, and educationally?

Identification/Screening

The effective use of psychotropic medication requires that all involved professionals be *strengths-based* with youth and family; and *trauma-informed* [4] (e.g. prioritizing safety, trustworthiness, choice, collaboration, and empowerment).

- ✓ An effective screening tool that can be used by child welfare workers is the *Child Welfare Trauma Referral Tool.* [5] This tool helps the worker determine which youth need to see a psychiatrist on an emergency basis, those who may need medication for a mental health disorder, and those who need trauma-specific treatment and possible medication use.

What screening tool(s) does your county utilize to ensure that dependent youth are being fully assessed to determine if psychotropic medications are necessary?

Who is responsible for ensuring the outcomes of the screening is utilized?

Assessment for Psychotropic Medications

It is best practice to use psychotropic medication as part of a comprehensive treatment plan that addresses the bio-psycho-social-cultural needs of the youth.

- ✓ Current protocols for the use and monitoring of psychotropic medication for dependent children includes a full psychiatric evaluation, done in the Life Domain Format [6], which includes relevant information regarding the child's strengths, functioning in the home, school, and community environment; relationships with peers; drug and alcohol involvement; medical/developmental history, prior mental health treatment history, medication history and trauma history; and the identification of the presenting concerns, specifically the nature, frequency, severity, and history of the behaviors and symptoms.

Not all counties in the Commonwealth have treating psychiatrists. Many children/adolescents are prescribed psychotropic medications by their primary care physician.

Given that psychotropic medication use in a pediatric population is typically a complex process, youth and family education, informed decision making, and open communication among all parties are especially important. Partnerships involving the use of psychotropic medication are at least as important as other aspects of treatment and care.

- ✓ Current prescribing doctors should have a discussion concerning their reasons for specific psychotropic medications that is being recommended along with side effects/risks with all members of the child's team, including the child (as age appropriate), parents or other caregivers, resource family/placement provider, CYS staff, GAL/legal representative, school, and the current treatment provider.

What are the resources available in your county related to the assessment and prescribing of psychotropic meds?

What protocols are in place in your county to ensure the prescriber's information is current and relevant to the child's situation?

How does your county collaborate with the prescriber and promote enhanced communication among all stakeholders so that pertinent information is being shared to ensure a comprehensive bio-psycho-social-cultural evaluation is completed?

Who is responsible in your county to ensure collaboration includes all members of the child's team, including family and/or natural supports?

Does the child receive a thorough health evaluation to identify any acute medical problems prior to the administration of psychotropic medications?

What do you see as your county's strengths and assets in providing a comprehensive treatment plan?

What could be put in place to improve collaboration and assessments in your county?

Medication Practices

Informed consent [7] means that the consenting party has been educated as to the potential benefits and possible side effects of the proposed medication, and willingly decides that the potential benefits of the medication outweigh the possible side effects.

What specialized staff positions do you have within your county that might provide expertise in psychotropic medication use?

What trainings are available to staff to support best practice in medication practices?

Who is providing consent for pharmacotherapy services? Are they informed?

How are children and family/natural supports involved in service delivery?

How is it assured that youth are empowered to have a voice and be a part of the treatment/medication process?

What coordination of service is available?

What expectations and practices exist to ensure coordination is occurring among the principal parties (child/adolescent's team)?

Referral/Psychosocial Interventions

The goal of treatment involves the promotion of youth adaptation and resilience and not just symptom reduction. Psychotropic medication should be part of an integrated treatment process and only rarely used alone. When indicated, psychotropic medication is best given in association with effective psychosocial interventions and use of natural supports. [8]

What services are available in your county to replace or complement the use of psychotropic medication? Are the youth who are prescribed medications receiving other interventions?

What evidence-based treatment models are in practice in your county?

What trauma-specific services are available in your county? What would it take to create a trauma informed system?

What are the access or quality issues with providers/programs?

How are services accessed and coordinated when children are placed outside the county or state?

How are youth and family involved in the process of decision making regarding psychosocial interventions?

Oversight and Monitoring

In October 2008, President Bush signed into law the Fostering Connections to Success and Increasing Adoptions Act. [9] This law requires state child welfare agencies and Medicaid to provide ongoing oversight and coordination of medical and mental health services, including psychotropic medications, for youth in foster care. Plans for oversight and coordination should:

- ✓ Promote collaborative efforts between child welfare agencies, Medicaid, pediatricians, and other experts to monitor and track medical and mental health;
- ✓ Include medical and mental health evaluations, both on entry into foster care and periodically while in foster care; and
- ✓ Provide continuity of care and oversight of medication use.

In Pennsylvania, the Behavioral Health Managed Care Company (BH MCO) covers assessment, prescription, and therapeutic services, but medications are funded through the Physical Health Managed Care Company (PH MCO).

- ✓ Each PH MCO has an established formulary of psychotropic medications they will cover. This can complicate children/adolescents receiving the appropriate psychotropic medication prescribed.

Who is the behavioral health and physical health managed care organization in your county? Who is your point of contact at that organization?

What services are available in the county through Health Choices and the child welfare system?

What is the role of managed care organizations for children in substitute care outside of the county?

Has your county worked on the creation of guidelines and/or a policy regarding oversight and monitoring of psychotropic medication prescribed to youth?

- ***What standards and protocols are in place in your county for monitoring and overseeing the prescribing practices and use of psychotropic medications for dependent children?***

- ***Who checks/confirms administration/monitoring of medication?***

- ***How do you screen for potential red flags? What is your plan of response?*** [10]

Is there collaboration between the court and child welfare agency to provide oversight of psychotropic medication for dependent children?

What would it take to have a responsible, acceptable plan for quality screening, assessing, prescribing and monitoring the use of psychotropic medication for children placed in foster care in your county, both individually and systematically?

Data

PA should lead the nation in providing the most protection and best practice around the use of psychotropic medications for youth in out of home placements. How many youth in your county are dependent? How many are in foster care? Group homes? Residential placements? What is the medication trend in each of these placement categories?

Who is tracking the data in your county? What data systems are in place to provide information on monitoring the trends of psychotropic medication prescribing?

What are your county's fiscal, human, and technological resources?

Can you identify connections to certain practices or agencies for patterns of prescribing?

How can you create a better database for when children enter care, move location, or change MCO that would provide for continuity of care policies?

In which ways can data be shared to promote better collaboration between physical and behavioral health providers?

Which Universities in your area could assist your county in the creation of a database or other data collection methods?

FUTURE PLANNING

Congratulations on reaching the end of what has hopefully been a rich and meaning discussion in your county! Think about all that you have learned in the process to answer the next set of questions.

Which areas do we need to address to ensure that our dependent children are getting all the support that they need to address their mental health issues and nothing that is not helpful, ineffective or unnecessary?

What is our priority task?

Who else needs to be at the table to move forward with the discussion and plans for change for our system?

Footnote citations

1. Raghavan, R; Zima, BT; Anderson, RM; Leibowitz, AA; Schuster, MA; & Landsverk, J. (2005). Psychotropic medication use in a national probability sample of children in the child welfare system. Journal of child and adolescent psychopharmacology. 15(1):97.
2. Ibid.
3. Multi-State Study on Psychotropic Medication Oversight in Foster Care/ Tufts Clinical and Translational Science Institute September 2010
4. What is Trauma-Informed Care? What are Trauma-Specific Services? http://parecovery.org/documents/Child_Adolescent_Best_Practices_2007.pdf *www.samhsa.gov/nctic/trauma.asp :* Treatment & Trauma-Informed Care
5. Child Welfare Committee, National Child Traumatic Stress Network. (2008). Child welfare trauma training toolkit: Comprehensive guide (2nd ed.). Los Angeles, CA & Durham, NC: National Center for Child Traumatic Stress.
6. Life Domain Format for Psychiatric /psychological Evaluations Initial and continued care. http://www.ccbh.com/pdfs/providers/healthchoices/forms/all%20counties/BHRS/Life Domain format psych evaluations pdf. ; www.nctsn.org/
7. Hodas, Gordon R, MD. PA/Policy/Meds and Foster Care/Steering Committee/Informed Consent-Draft-0213
8. Guidelines for Best Practice in Child and Adolescent Mental Health Services. www.dpw.state.pa.us/ucmprd/groups/public/.../s_001583.pdf
9. Fostering Connections to Success and Increasing Adoptions Act. Public Law 110-351.
10. To Each What They Need: Monitoring and Oversight of Psychotropic Medication for Dependent Children Psychotropic Medication Workgroup May 2012 ; http://www.ocfcpacourts.us/assets/files/page-376/file-1102.pdf.

KEY QUESTIONS WHEN A CHILD IS ON PSYCHOTROPIC MEDICATIONS

ASK THE CHILD:

1.	(Quantity)	What medications do you take?
2.	(Diagnosis)	What is the medication supposed to do for you?
3.	(Length)	How long have you been taking the medication?
4.	(Compliance)	Do you always take it as prescribed?
5.	(Side Effects)	How does the medication make you feel? Any side effects?
6.	(Effectiveness)	Do you feel the medication is working?
7.	(Monitoring)	How often do you see the doctor and who goes with you?
8.	(Communication)	Do you feel the doctor listens to you?

ASK THE CAREGIVER (In addition to 1-8 above):

9.	(Changes)	Any changes in medication, dosage or frequency during the last review period?
10.	(Authorization)	Who authorized the medication/changes?
11.	(Consent)	Are you asked for consent for changes in medication?
12.	(Administration)	Who administers the medication? Who stores the medication?
13.	(Compliance)	Is there adherence to the medication regiment?
14.	(Effectiveness)	Are there measurable changes in the child's behavior or mood?
15.	(Advocating)	Is the doctor responsive to your questions/concerns?

ASK THE CASEWORKER/PROVIDER/GAL (in addition to 1-15 above):

16.	(Initiation)	When was a diagnosis made requiring medication and by whom?
17.	(Evaluation)	Date of last psychiatric evaluation?
18.	(Record)	Is the medication noted in the record/Permanency Plan/Transitional Plan?
19.	(Drug Classes)	How many of a particular classification of medication does the child take?
20.	(Necessity)	Is there evidence to support the necessity for the medication? What is it?
21.	(Services)	What other interventions and therapies have been/are being attempted?
22.	(Benefits/Risks)	What are the benefits and risks of the medication? How will it improve the child's life? Are all parties aware of the benefits/risks?
23.	(Monitoring)	Is there any lab work necessary to monitor the use of the medication? Schedule?
24.	(Second Opinion)	Is a second opinion warranted?

BEST PRACTICES:

- Prior to prescription of medication, ensure performance of a psychiatric evaluation, with accurate medical, behavioral and psychological history provided from parents, educators, past providers, and current caregiver.
- Information used in the evaluation is provided from multiple sources.
- Parents, caregivers, caseworker and GAL are notified of medication appointments.
- Child, caregiver, and parents are present, if possible, at appointments.
- Promote family and youth have a voice during psychiatric evaluations and medication visits.
- Focus on the strengths of the child, not just the concerns.
- Informed consent is given from youth/family for medication usage.
- Regular written reports should be obtained from appropriate treating medical professionals.
- Ensure youth/family execute consents for release of information from providers.
- Ensure the child is receiving appropriate therapeutic interventions and connection with natural supports utilized concurrently with medication.
- Confirm coordination of efforts and open lines of communication among case workers, service providers, teams, psychiatrist and therapist.
- Ensure that planning for ongoing monitoring of medication includes a plan for when the medication is no longer needed.

RED FLAGS:

- Three or more psychotropic medications.
- More than one medication per drug classification.
- Use of medication for purposes other than its primary indication.
- Psychotropic medication prescribed for children ages five (5) or younger.
- Pediatrician prescribing psychotropic medication without psychiatric consultation.
- No plan for transitioning from child to adult system for youth 16 or older with ID/MH issues.

For more information on psychotropic medication, go www.ocfcpacourts.us and click on workgroups