Georgia Psychotropic Medication Monitoring Project

Presented by the Barton Child Law & Policy Center of Emory University School of Law in collaboration with Casey Family Programs and the Child Welfare Collaborative

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Executive Summary
The proliferation of psychotropic medication use for the treatment of mental and behavioral health disorders among children in foster care has captured the attention of clinical researchers, child welfare professionals, state and national policymakers, and the public at large. Recent studies consistently document higher rates of utilization in the foster care population than are seen in the overall youth population and comparable populations of Medicaid-eligible youth. Polypharmacy is also more common among children in foster care, particularly combinations involving antipsychotic medications. These trends are disturbing because the safety and effectiveness of many of these medications has not been established, particularly for use with children. Additionally, these medications are costly to state Medicaid programs.

In collaboration with Casey Family Programs, the Barton Child Law and Policy Center and Child Welfare Collaborative led a year-long project to examine the state’s capacity for oversight of the administration of psychotropic medications to children in foster care. The Georgia Psychotropic Medication Monitoring Project included comprehensive medical and legal research; review of agency policies; clinical review of select foster care cases and consultation by an independent child psychiatrist; and training for caseworkers, foster parents, attorneys, judges, and Court Appointed Special Advocates. Its aim was to facilitate the state’s compliance with federal mandates requiring increased oversight and specific protocols for the administration of psychotropic medications to children in foster care.

Review and analysis of Medicaid claims data indicates that Georgia exceeds the national averages for use of psychotropic medications and antipsychotic medications, in particular, in the state’s foster care population. File reviews of 93 cases of children experiencing extended stays in foster care revealed concerning trends in prescribing practices, including frequent polypharmacy, sometimes used for behavioral control of children. Deficiencies were noted in casework practices for obtaining and documenting informed consent, in part due to the failure of agency policies to clearly identify who is authorized to give informed consent and to address overreliance on blanket authorizations. Furthermore, child welfare policies and practices disregard the importance of obtaining the child’s assent to treatment. The state also lacks the infrastructure and recommended features of a formal oversight system, including a consultation program to connect child welfare personnel and clinicians with expertise; protocols for routine coordination, data-sharing and reporting between the state’s child welfare, mental health and Medicaid agencies; and training for caseworkers, court personnel, foster parents and other system stakeholders.

Because of their powerful treatment effects and budgetary impact, administration of these medications deserves closer scrutiny, especially when prescribed for youth in foster care. Toward that end, the Georgia Project presents the following recommendations for systemic oversight of psychotropic medication use among children in foster care:

1) DHS-DFCS policy should clearly address whether the administration of psychotropic medication is to be considered “routine medical care” as part of the agency’s legal duty to ensure the needs of children in foster care are met and provide informed consent;

2) DHS-DFCS policy should clearly identify who is authorized to provide informed consent to medication treatment for a child in foster care (caseworker, administrator, parent/guardian, foster
parent, etc.) and outline the responsibilities of that role;

3) DHS-DFCS should develop clear practice guidance and/or policy to facilitate consistent and meaningful engagement of the biological parent(s) in the course of the child’s treatment, including how the agency should respond to parental requests for changes in treatment;

4) DHS-DFCS should develop clear practice guidance and/or policy to facilitate consistent and meaningful engagement of the child or youth, including procedures for obtaining the youth’s assent to the recommended treatment;

5) DHS-DFCS should adopt a standardized written consent form to facilitate proper, individualized treatment for every child in foster care who needs mental or behavioral health interventions; alternatively, DFCS should coordinate efforts with DBHDD to develop and consistently employ a provider-specific consent form;

6) DHS-DFCS should implement quality assessment measures to ensure proper documentation of the agency or parent’s informed consent and the child’s assent in the case record, including current and complete information entered into the Health Log pages in SHINES;

7) DHS-DFCS should actively explore expanded adoption of an electronic medical passport model, beginning with existing capacity in SHINES;

8) DHS-DFCS should develop explicit protocols for sharing individual case-level information (maintained electronically or in paper form) with treatment providers, foster parents or other caregivers, the child’s attorney or guardian ad litem, and the court, as needed;

9) DHS-DFCS should adopt an express prohibition in policy against the use of psychotropic medications as chemical restraints and for purposes of punishment or convenience of the caregiver, staff, or parent;

10) DHS-DFCS should adopt an express prohibition in policy against the use of as-needed/blanket/pro re nata authorizations;

11) DHS-DFCS, in partnership with DBHDD and DCH, should develop a training curriculum and educational opportunities for agency personnel and system stakeholders (foster parents, judges, attorneys, Court Appointed Special Advocates) to improve understanding of the mental and behavioral health needs of children in foster care, available medication treatments, and nonpharmacological alternatives to medication;

12) DHS-DFCS should coordinate with its sister agencies DBHDD and DCH to promote awareness of and adherence to the DBHDD medication utilization standards among clinicians treating children in foster care through strengthened contract standards or other quality assurance mechanisms;

13) DHS-DFCS should partner with its sister agencies DBHDD and DCH to develop a coordinated response to foster care providers/mental health service contractors identified for problematic prescribing patterns;
14) DHS-DFCS should partner with its sister agencies DBHDD and DCH to build capacity among providers offering nonpharmacological, psychosocial therapies;

15) DHS-DFCS should develop a consultation program under the direction of the new Medical Director, including the essential components of a process for review of “red flag” cases and face-to-face evaluations of children upon proper request;

16) DBHDD should consider the technical revisions to its medication utilization parameters suggested by the clinician workgroup convened as part of the Georgia Project;

17) DCH should continue monitoring the impact of its prior authorization program and make results available through periodic public reporting;

18) DCH should solicit clinician and consumer input concerning any modifications to its prior authorization program;

19) DHS-DFCS, DBHDD, and DCH should establish inter-agency monitoring and information-sharing protocols regarding case-level and aggregate utilization trends (rate and type), adverse events, and outlying prescribers and share relevant detail with county offices;

20) DHS-DFCS, DBHDD, and DCH should engage in routine reporting to the field and the public on aggregate trends in psychotropic medication utilization (rate and types) and adverse events experienced by children in foster care;

21) DHS-DFCS, DBHDD, and DCH should consider centralizing relevant policies, procedures, and educational materials on a public website accessible by clinicians, foster parents, and other caregivers.