Psychotropic Medication Management for Youth in State Care: Consent, Oversight, and Policy Considerations

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Consent

State and county child welfare agencies have established a variety of means of providing consent for prescribing psychotropic medications for youth in state custody (Table 1). The most common method is for the legal guardians or parents to give consent (n = 8), followed by caseworkers (n = 7), and court order (n = 6). Other states have designated specific officials or created specific offices within the child welfare agency to provide consent for psychotropic medications. In Illinois, the Department of Guardian and Advocacy was established to provide consent for medical care, including treatment with psychotropic medications. In Connecticut, Program Supervisors provide consent, whereas 12 regional health nurses have this responsibility in Tennessee.

Court consent is required prior to administering psychotropic medications to children in custody in six states, though in some instances only if the biological parents cannot be located. Judicial consent must be obtained before an antipsychotic can be prescribed in residential treatment centers in Massachusetts, though court consent is not required for other psychotropic medications.

Consultation

Seven state child welfare agencies use mental health and psychiatric consultation as part of the consent process. In Illinois, DCFS contracts with the University of Illinois at Chicago to provide an independent review of all psychotropic medication requests by a board certified child and adolescent psychiatrist for youth in state care. In addition, consultation is available to case managers to review the appropriateness of a child's diagnosis and medication regimen and to treat clinicians for particularly complex cases.

Tennessee requires that all psychotropic medication requests for youth under age 5 be approved by a psychiatrist in the Department of Children's Services central office and that all consent requests for youth aged 6-10 be reviewed by the nurse practitioner and the psychologist or psychiatrist in the central office before the treating clinician can start the medication. Additional consultation to clarify the appropriateness of a consent request can be obtained from one of three Centers of Excellence for Children in Custody located at the University of Tennessee Memphis, Vanderbilt University, and East Tennessee State University.

In Connecticut, Program Supervisors must consult with medical specialists in the department at one of three levels prior to consenting to administering psychotropic medications. A Level I consultation with a Regional Resource Group (RRG) Nurse is necessary for psychotropic medication requests for children under 5 years and for any child on more than two psychotropic medications. A Level II consultation by the RRG Nurse and the Director of Psychiatry is required for any child with complex medical needs, the use of more than four psychotropic medications, and the use of nonformulary medications. A Level III consultation by the RRG Nurse, the Department of Children and Families (DCF) Physician or Director of Psychiatry, and the Department Psychiatric Review Board is mandated for children with chronic or recurrent psychiatric disorders that include a threat of harm to self or others or with grave disability unresponsive to multiple psychiatric interventions and whose treatment may require the use of nonstandard treatment modalities.

Oversight

Most states provide informal case level oversight of psychotropic medication usage through ongoing child and family treatment planning conferences. The caseworker from the child welfare agency, the child's attorney, the foster parent or representative from the child's current placement, the advocacy programs representing the child, the program manager for the behavioral health section of the child welfare agency, the mental health clinicians, and other stakeholders provide some degree of oversight of the treatment plan and the use of psychotropic medications.

Several states have developed specific programs to monitor the use of psychotropic medications (n = 11). State oversight can be case-specific, for example, overseeing the appropriateness of a particular youth's pharmacological regimen. The Florida Department of Children and Families provides an update to the court detailing the child's medical and behavioral status as part of the regular social services report for judicial review hearings. The update reviews the child's psychotropic medication management and all pertinent medical records that have been generated since the last review. The court may order the child welfare agency to obtain a second opinion addressing the safety and appropriateness of the continued use of psychotropic medications or order additional consultation with the MedConsult line at the University of Florida.

Some state agencies have devised system-wide strategies to oversee the use of psychotropic medications. Some states, such as Arizona and Texas, have devised best practice protocols to enhance the quality of psychotropic pharmacotherapy. These guidelines serve to establish minimal standards against which the quality of clinical care can be measured. In Arizona, the Division of Behavior Health Services has developed a Practice Improvement Protocol entitled *The Use of Psychotropic Medication in Children and Adolescents* that offers guidelines for prescribing psychotropic medications to children. Regional Behavioral Health Authorities are charged with the responsibility of monitoring prescribing psychotropic medications by reviewing utilization data, prescribing patterns, and peer review to identify unsafe or unsound prescribing practices and to implement improvement actions. The Texas Department of Family and Protective Services (DFPS), in conjunction with a panel of child and adolescent psychiatrists, psychologists, and other mental health professionals, recently developed best practice guidelines, *Psychotropic Medication Utilization Parameters for Foster Children.*

Three states, Connecticut, Illinois, and Tennessee, have established databases to monitor the use of psychotropic medications in children and adolescents in state custody. These databases allow the state's child welfare agency to track informed consent for psychotropic medications documentation and to review prescribing patterns by placement, discipline, region, or individual clinician. Tennessee's database is maintained on the Department of Children's Services (DCS) intranet while University of Illinois- Chicago (UIC) maintains the consent database for the Illinois DCFS and has the capacity to cross-check consents with payment data from the Illinois Department of Public Aid. This enables the Illinois DCFS to document that medications have actually been dispensed and to monitor practitioner and caregiver compliance with the consent procedure.

State child welfare agencies often partner with the sister state agency that manages the state Medicaid program to provide oversight of use of psychotropic medications for children in foster care. In Pennsylvania, the Bureau of Data and Claims Management monitors the use of psychotropic medications for youth in countyadministered, state-supervised, substitute care. In North Carolina, a pharmacist or physician must review the psychotropic medication regimen of any child on Medicaid at least every six months. The Texas Health and Human Services Commission, which manages the Texas Medicaid program, is designing a physician-directed medical review process to evaluate psychotropic medication use in children under DFPS custody.

Pro Re Nata Medications

Pro re nata (PRN) medications are standing orders that allow caregivers in group home, residential, or hospital settings to administer a psychotropic medication for the emergency management of aggression, psychotic agitation, insomnia, and other troublesome symptoms without a physician assessment or specific approval. While the prescribing clinician typically sets parameters for the use of these medications, the decision to medicate is placed in the hands of the milieu staff, typically a nurse. While clearly not the intent, PRN medications may encourage reliance on the use of medications to manage disruptive behaviors rather than psychosocial or behavioral interventions. Illinois specifically prohibits the use of standing PRN medication orders, though the patient's physician can prescribe emergency medications without prior consent to manage an acute crisis after an appropriate assessment. All emergency medications are subsequently reviewed by UIC. Excessive or inappropriate use of emergency medications prompts an inquiry by the DCFS Department of Guardian and Advocacy or the Oftice of the Public Guardian into the child's treatment plan, the effectiveness of the placement, or the clinician's use of emergency medications.

In Tennessee prescribing PRN medications for youth in state care requires a separate consent that is reviewed by the regional health unit nurse and then sent to the DCS central office for approval by the psychologist or psychiatrist. Consent for PRN medications is time-limited. In Connecticut, standing PRN orders for psychotropic medications requires a Level I consultation with a Regional Resource Group (RRG) Nurse. In Alabama, administering PRN psychotropic medications two or more times weekly for three weeks will trigger a comprehensive case review of a child's service and behavior management plans.

TABLE 1
Summary of psychotropic medication consent procedure by state

STATE	SPECIFIC POLICY EXISTS FOR CONSENT PERSON AUTHORIZED TO GIVE CONSENT	POLICY EXISTS FOR OVERSIGHT OF CONSENT FOR PSYCHOTROPHIC MEDS	POLICY IMPLEMENTED AT STATE OR COUNTY LEVEL	MEDICATION REQUEST REVIEW OR CONSULT-ATION BY LICENSED HEALTH CARE PROFESSIONAL	USE OF FORMULARY[1]
Alabama	Yes - LG, P	Yes	State	No	Unk
Alaska	Yes-W	Unk	Unk	Yes	Unk
Arizona	Yes - CO, LG, P	Yes	State	No	Yes
Arkansas	Yes-W	No	State	No	No
California	Yes - CO	Unk	Unk	Unk	Unk
Conn.	Yes - LG, P	Yes	State	In some cases	Yes
Florida	Yes - CO	Yes	State	Unk	Unk
Georgia	In RTC - W	In some cases	County	No	Unk
Hawaii	In RTC - LG	No	State	Available	No
Illinois	Yes - LG	Yes	State	Yes	MA
Iowa	No	No	State	No	MA
Kansas	Yes - CA, P	No	State	No	No
Kentucky	Yes - P, W	No	Unk	Available	Unk
Louisiana	No	No	NA	NA	MA
Maryland	Yes-W	Yes	County	No	No
Massachusetts	Yes/antipsyc/CO	Unk	Unk	No	No
Minnesota	Yes - CO	Unk	Unk	Unk	Unk
Missouri	No	No	NA	NA	No
Montana	No	No	NA	NA	MA
Nebraska	Yes-W	Yes	State	Available	No
New Jersey	In RTC - LG, P	No	State	No	Unk
N. Carolina	No	No	County	No	No
No. Dakota	InRTC-LG	Unk	Unk	Unk	Unk
Ohio	No	No	County	No	No
Oklahoma	No	No	State	No	Yes
Oregon	No	No	NA	No	Unk
Penn.	Yes - CO	Yes	State	No	MA
So. Dakota	No	No	State	No	No
Tennessee	Yes - RN	Yes	State	Yes	MA
Texas	Yes - CA	Yes	State	No	MA
Vermont	Yes-W	No	Unk	No	No
Virginia	Unk	Unk	Local office	Unk	Unk
Wash.	Yes-W	No	State	No	MA
W. Virginia	In RTC - Unk	No	State	No	MA
Wyoming	No	No	State	No	Unk

1 information not avaiiabie on Colorado, Deiaware, District of Coiumbia, idaho, Indiana, Maine, fi/lichigan, fi/lissis-
sippi, Nevada, New Hampsfiire, New Mexico, Rtiode Island, South Carolina, Utah, and Wisconsin.
2 Information obtained exclusively from website.
3 Key: NA=Not Applicabie; CA=Custodial Agency; CO=Court Ordered; FP=Foster Parent; LG=Legal Guardian or
Designee; MA=Medicaid; P=Parenf; HN=Dept. Nurse; Unk=Unknown; W=Worker