



**Written Testimony of
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Ways and Means Committee
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Managing Psychotropic Medication Usage in a Child Welfare System

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Introduction

Thank you for the opportunity to submit testimony regarding the use of psychotropic medication among children in the child welfare system. My name is Tricia Lea, Ph.D., and I am submitting testimony on behalf of the State of Tennessee, where I serve as the Director of Medical and Behavioral Services for the Department of Children's Services (DCS), and the National Association of Public Child Welfare Administrators (NAPCWA), an affiliate of the American Public Human Services Association (APHSA). APHSA is a nonprofit, bipartisan organization representing state and local human service professionals for over 77 years. NAPCWA, created as an affiliate in 1983, works to enhance and improve public policy and administration of services for children, youth, and families. As the only organization devoted solely to representing administrators of state and local public child welfare agencies, NAPCWA brings an informed view of the problems facing families today to the forefront of child welfare policy. DCS is the agency responsible for our state's child welfare programs. The Department's mission is to empower families and support community safety and partnerships to help ensure safety, permanency and wellbeing for children in our care. The State of Tennessee is committed to protecting the children served in our child welfare system by ensuring that medical, mental and behavioral health services are provided in the least intrusive manner and in the least restrictive setting that meets each child's needs.

Background

The child welfare system in Tennessee serves over 20,000 children and youth at risk of custody each year and has approximately 8100 children and youth currently in custody. The Department of Children's Services has been under intense scrutiny since May 2000, when a civil rights class action lawsuit was filed by Children's Rights, Inc., on behalf of children who had experienced difficulties within the child welfare system. According to the complaint, Tennessee was not fulfilling its obligations to children in foster care, as children were staying in custody for long lengths of time, being placed in emergency shelters or congregate care settings rather than family-like settings, experiencing multiple placement moves, and not getting all of their healthcare and educational needs met. Additional concerns in the lawsuit focused on the inappropriate use of psychotropic medications for children in care, inadequate monitoring of psychotropic medications, and the possible use of these medications as a means of control, punishment or discipline of children or for the convenience of staff providing care to foster children.

A settlement agreement was finalized in the lawsuit in July 2001. This agreement became known as the Brian A. Settlement Agreement, as it was named after one of the eight foster youth for whom the original lawsuit was filed. This settlement established the outcomes to be achieved by the State of Tennessee on behalf of children in custody and their families. It also mandated the creation of the Technical Assistance Committee (TAC) consisting of experts in the child welfare field to serve as a resource and monitoring function for the Department in the development and implementation of its reform effort. The Settlement Agreement also required that Tennessee DCS review all policies and procedures surrounding the use of psychotropic medication, that DCS implement all recommendations made by TAC, and that the Department hire a full-time

Medical Director specifically to oversee the implementation of policies and procedures concerning the use of psychotropic medication for children in DCS custody. I serve in this Medical Director position and would like to share with you one child welfare agency's progress in the area of psychotropic medication.

First Area of Reform: Evaluation of Current Policies and Practices

The first phase of reform for Tennessee was to conduct an in depth evaluation of current policies and practices regarding psychotropic medication. The Department conducted this analysis with the assistance of Dr. Christopher Bellonci, an expert child psychiatrist and consultant provided by the Child Welfare League of America. Dr. Bellonci and I co-facilitated a multidisciplinary workgroup that included psychiatrists, psychologists, nurses, and other leadership and field staff from the Department of Children's Services, the state Department of Mental Health and Developmental Disabilities, provider trade organizations, and provider agencies serving children in custody. The guiding principles developed by this group included:

- DCS will ensure that psychotropic medications prescribed for children in custody are used in combination with other therapeutic modalities contained in a multidisciplinary treatment plan.
- DCS will ensure that parents and children are offered an opportunity for meaningful participation and input in the decision making process related to the possible use of psychotropic medications.
- DCS will ensure that psychotropic medications are properly administered and that custodial children receiving the medications are properly supervised to ensure consistency and continuity in their care and treatment.
- DCS will ensure that the efficacy, safety and side effects of psychotropic medications used with children in custody are tracked and documented.
- DCS will ensure that psychotropic medications are not used as a means of control, punishment or discipline of children or for the convenience of the treating facility.
- DCS will prohibit the use of psychotropic medications on a *pro re nata* (as needed) basis without the prior authorization of the DCS Director of Medical and Behavioral Services or his/her designee.
- DCS will ensure that direct-care staff are trained in the use, administration, and monitoring of psychotropic medications with children.
- DCS will monitor and track the prescribing practices of psychotropic medications to include ethnic, gender, age and trends for children in DCS care.

These principles were included in the "DCS Standards of Professional Practice for Serving Children and Families", which is a document outlining the vision of the Department to ensure quality care, appropriate service, safety and permanency for children and families in Tennessee.

Second Area of Reform: Policy and Practice Development

These principles also guided the development of five policies related to the use of medication, including policies about medication administration, emergency and PRN usage of psychotropic medication, medication errors and informed consent. The Brian A.

Settlement Agreement outlined specific practices to follow regarding the process of informed consent and psychotropic medications, specifically that “whenever possible, parents shall consent to the use of medically necessary psychotropic medication.” When parents are not available or their legal rights have been terminated, then DCS regional nurses review and provide consent to medically necessary medication. DCS developed a statewide network of nurses to monitor healthcare for children in custody, including the use of psychotropic medication.

Monitoring Guidelines and Procedures

In addition to assisting in policy development, Dr. Bellonci drafted the “DCS Medication Monitoring Guidelines” referenced in his testimony, as a tool for DCS case managers to use in monitoring the psychotropic medications prescribed for the children in their care. As Dr. Bellonci has noted, these guidelines were not meant to define prescribing practices but to help inform decision making and oversight related to psychotropic medication usage for children in foster care.

Once the DCS medication policies and monitoring guidelines were promulgated and shared with contract providers, DCS required each provider agency to complete a “self-assessment” of their compliance level with every practice mandated in each of the medication policies. The Department used these data as a baseline for ongoing monitoring that occurs each year by our internal auditors. Those providers who were not in compliance were also required to submit corrective action plans to be used by DCS for ongoing evaluation and technical assistance. In addition to annual site reviews, DCS also conducts unannounced site visits to residential facilities by multidisciplinary teams consisting of regional and central office DCS personnel. These site visits consist of interviews with staff and youth, as well as intensive reviews of personnel, training and clinical records to determine whether these programs are implementing the protection from harm policies (those dealing with psychotropic medication as well as restraint and seclusion).

Training

The Department developed specific training curricula for agency staff and contract providers in order to assist with the implementation of these protection from harm policies. One training focuses on educating DCS staff, providers, and resource parents about policies related to psychotropic medication usage. This computer-based training utilizes case vignettes, challenge questions, and expert resources to spark discussion among individuals serving children. Another training curriculum teaches resource parents how to properly administer, store, dispose of and monitor medication use for children and youth in their homes. These training modules have been shared with the provider agencies caring for DCS children in TN, as the Brian A. Settlement Agreement suggests that all DCS staff and private agency staff serving children in custody should be trained similarly.

Audits

As part of the ongoing monitoring mandated by the Brian A. Settlement Agreement, the Technical Assistance Committee audits a sample of case records of children in custody of

the state of Tennessee. Regarding psychotropic medication, these reviews focus on determining how many children are prescribed psychotropic medication, the ages and placements of these children, and whether or not appropriate informed consent was obtained for the psychotropic medications.

The first case file review conducted by the Federal Monitor was completed in 2004 and reviewed data from 2003. This review found that approximately 25% of children in custody were prescribed psychotropic medications. The next case file audit reviewed data from 2004 and was completed in 2005, finding that only 17% of children in the sample were prescribed psychotropic medication. This sample was somewhat different from the previous year, in that it reviewed children just entering the child welfare system who had only been in custody approximately six months. The TAC also conducted a review of DCS case files in 2006 (looking at practice in 2005), which found that 21% of children in custody were administered psychotropic medication. Despite some fluctuation, the numbers of children prescribed medication has declined. The majority of children prescribed psychotropic medication each year has been the adolescent population.

	2004 n = 106	2005 n = 276	2006 n = 268
Case file documents child was administered psychotropic medication during review period	25%	17%	21%

Percent of Children in Each Age Range Administered Psychotropic Medication	2004	2005	2006
0 – 3 years	0% (0 of 106)	0% (0 of 81)	0% (0 of 69)
4 – 6 years	11% (5 of 47)	9% (3 of 34)	3% (1 of 30)
7 – 9 years	25% (15 of 59)	3% (1 of 29)	32% (6 of 19)
10 – 12 years	33% (18 of 55)	24% (8 of 33)	37% (11 of 30)
13 – 18 years	40% (68 of 171)	34% (34 of 99)	33% (34 of 120)

Informed Consent for Administration of Psychotropic Medication Received	2004	2005	2006
Informed Consent given	69%	60%	70%
No informed consent	33%	40%	30%

Third Area of Reform: Tracking Data Trends

In order to provide additional expertise, consultation, review and oversight with regard to psychotropic medication, TN DCS employed a Child and Adolescent Psychiatrist, Deborah Gatlin, M.D. Dr. Gatlin has established a Pharmacy and Therapeutics Committee, whose membership includes psychiatrists and pharmacists with special expertise related to child and adolescent care. This group reviews medication practice across the state and advises on issues related to mental health treatment for children in custody. Our various review initiatives identified children taking as many as eight different psychotropic medications. There appeared to be, in some instances, a lack of oversight for medication management and drug interactions.

As a mechanism of tracking psychotropic medication usage for children in foster care, DCS worked with TennCare (Tennessee's Medicaid program) and TennCare Select (the Managed Care Company serving children in custody) to receive paid claims data for children and identified psychotropic medications. Blue Cross and Blue Shield provided this pharmacy data to the Department, and this information was matched against the child welfare database (TNKids) for each month. Summary data from January – December 2006 indicates that on average, 19.8% of children in DCS custody were prescribed at least one psychotropic medication during the calendar year. The providers prescribing the most medications to Tennessee's custody children were physicians specializing in psychiatry. The classes of drugs prescribed the most during 2006 included antipsychotics and stimulants (e.g., Seroquel and Adderall). During 2006, three-fourths of the 19.8% of children on medication received only one or two psychotropic medications (44.8% and 31.0%, respectively); 16.4% received three psychotropic medications, and less than 1% received four or more psychotropic medications concomitantly. A child in the custody of the State of Tennessee who was administered medication during 2006 was more likely to be a white male, adjudicated dependent and neglected, age 13 years, and prescribed approximately two psychotropic medications by a psychiatrist. The research division of DCS is currently analyzing the pharmacy claims data for the 2007 calendar year, but trends from the second quarter of 2007 indicate similar numbers of children on psychotropic medications (an average of 20.1%). Additionally, 2007 data show that of those 20% of youths receiving psychotropic medications, the majority (an average of 75%) are prescribed only one or two medications.

Fourth Area of Reform: Updating Monitoring Guidelines and Protocols

In conjunction with the Pharmacy and Therapeutics Committee, the DCS Consulting Psychiatrist, Dr. Gatlin, has formulated updated medication monitoring guidelines for use in Tennessee. These "Psychotropic Medication Utilization Parameters" were adapted from the original "DCS Medication Monitoring Guidelines" as well as the Texas Department of State Health Services standards. These parameters outline situations in which further review of a foster child's medication regimen is warranted. These guidelines do not indicate if the treatment is inappropriate, but indicate that further analysis of the situation is needed. The new parameters include:

- Four or more psychotropic medications prescribed concomitantly

- Two or more psychotropic medications of the same class prescribed concomitantly (specifically antidepressants, antipsychotics, stimulants, and mood stabilizers)
- Medication dose exceeds the usual recommended dose (the Pharmacy and Therapeutics Committee drafted a listing of commonly used psychotropic medications used in the treatment of children and adolescents, outlining maximum dosages)
- Children under five years of age prescribed psychotropic medications

Cases that fall outside of the DCS medication monitoring guidelines are reviewed at several levels. The state of Tennessee is fortunate to have regional health units staffed with nurses and psychologists in each of the 12 regions of the state. Additionally, in central office, we have our consulting child psychiatrist (Dr. Gatlin) as well as a pediatric nurse practitioner. Outside of DCS, we have five “Centers of Excellence for Children in State Custody” that are a partnership with the State of Tennessee and academic medical centers and community providers. The Centers of Excellence (COEs) were created to serve children in and at risk of custody and provide expert guidance for the diagnosis and treatment of medical and behavioral health disorders for all community providers. The COEs also offer limited direct services for the most complex cases of children in and at risk of custody and for situations in which service gaps exist.

While reviews of individual cases that fall outside of these medication parameters have been reviewed at numerous levels for some time, the DCS child welfare database has now automated these reviews. Since August of 2007, when medication information is input into the database, a review by the psychiatrist is automatically triggered. An e-mail alert is sent to our consulting psychiatrist for further review. Dr. Gatlin’s reviews of these cases have typically indicated that more clinical information is needed to understand the situation, that the treatment is within reasonable clinical community standards, that consultation with a Child and Adolescent Psychiatrist or Center of Excellence is indicated, or the child’s case should be transferred from the Primary Care Provider (PCP) to a Psychiatrist. The majority of cases falling outside the psychotropic medication parameters have indicated appropriate care. The updated DCS database also mandates that consent information for each psychotropic medication is documented. In Tennessee, youths aged 16 years and older have the same legal rights to consent to mental health treatment including psychotropic medications as adults. The database requires an explanation if a youth is 16 years of age or older and was not the person who gave consent for the psychotropic medication. Similarly, the Brian A. Settlement Agreement mandates that whenever possible, parental consent should be obtained for psychotropic medications. If parental rights are not terminated, the new data system forces an explanation if the parents did not provide the informed consent.

The updated database also allows for more accurate tracking of health information for children in custody, including allergies, medical conditions, psychiatric diagnoses, all medications (including psychotropic), and documentation of all health services rendered to the child (including medical, dental, vision, and mental health). The system allows for a summary to be developed, which acts as a “Health Passport” for the child to ensure that

all caregivers and providers serving the child have clear information on the child's history and current health status. This summary is shared with case managers, healthcare providers, placement agencies, and resource parents. This is similar to the passport that the state of Texas has developed as a part of its STAR Health program

DCS is now working on contrasting the pharmacy claims data with the data in our child welfare database to ensure that we are adequately tracking all children in custody who receive psychotropic medications. Additionally, the Pharmacy and Therapeutics Committee continues to act in an advisory capacity for this process and will be used to review individual providers who have concerning prescribing practices in comparison to the drug utilization parameters used in Tennessee.

We are able to see cases in which children and youth in our custody have benefited from the oversight and monitoring processes we have put in place. One example is that of a 14 year old boy, in full guardianship, with diagnoses of Mild Mental Retardation, Bipolar Disorder, Impulse Control Disorder, and Psychotic Disorder. He was placed at a residential treatment facility but continued to require frequent psychiatric hospitalizations and was prescribed six psychotropic medications (two antipsychotics, two mood stabilizers, one sedative, and an additional medication for impulse control). When the DCS regional nurse reviewed these medications to give consent, she contacted our Child and Adolescent Psychiatrist as the medication regimen met several of the monitoring triggers. The Psychiatrist was concerned about the youth's placement moves and frequent medication changes and recommended that his psychiatric care transfer to one of our Centers of Excellence. The youth has been taken off several of the psychotropic medications, is now placed in a foster home rather than a residential facility, and is doing fairly well.

The State of Tennessee Department of Children's Services has made significant progress regarding psychotropic medication practices for children in custody. We recognize that there is a high rate of mental illness associated with our population and that there is trauma associated with entering the foster care system. However, Tennessee is working to ensure that children in custody have their mental health needs adequately addressed and are prescribed psychotropic medication when clinically indicated. In those cases, we want to ensure that appropriate informed consent is given and ongoing monitoring occurs. Additionally, Tennessee is working diligently to ensure that psychotropic medication is not used inappropriately or as a means of control, punishment, and discipline of children or for the convenience of staff.

Thank you very much for the opportunity to speak to this important issue affecting the children of our country.

