A MISTREATED EPIDEMIC: STATE AND FEDERAL FAILURE TO ADEQUATELY REGULATE PSYCHOTROPIC MEDICATIONS PRESCRIBED TO CHILDREN IN FOSTER CARE

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"I was over-diagnosed and over-medicated. I was depressed and emotional when I first entered care and I did not respond to antidepressants. So they thought I had something more serious, but what I had was a life problem."[1]

Foster children are prescribed psychotropic medications at alarmingly high rates. Some studies indicate that up to fifty percent of all children in foster care are prescribed one or more psychotropic medications at a given time. These rates indicate that epidemic numbers of children in state care are on mind- or mood-altering medications. Given that available mental health care for children in state custody is woefully inadequate, these rates also suggest that psychotropic medications are being used to manage—not treat—children in care. Yet, many states and the federal government have been exceedingly slow to implement policies that meaningfully regulate how psychotropic medications are prescribed to children in foster care. The result is a serious risk of harm to children from the medications' side effects, and a high likelihood that the child's underlying mental health, behavioral, or emotional issues will not be treated beyond the "quick fix" that psychotropics offer.

This Article explores the psychotropic medication epidemic in the child welfare system and how broad failures by states to attend to the mental health needs of dependent children, along with existing child welfare policies, have contributed to this epidemic. The Article reviews the role federal legislation has had on the psychotropic epidemic and what role the Fostering Connections Act may have on how psychotropics are prescribed. It concludes by reviewing specific action states have taken to regulate psychotropic medications, and offers best practices to help ensure that psychotropics are legally prescribed in therapeutically appropriate ways.

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1. *Prescription Psychotropic Drug Use Among Children in Foster Care: Hearing Before the Subcomm. on Income Sec. and Family Support of the H. Comm. on Ways and Means*, 110th Cong. 34 (2008) (statement of Misty Stenslie, MSW, Deputy Dir., Foster Care Alumni of America) (quoting anonymous alumna of Ohio foster care).

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I. INTRODUCTION

Desiree was placed in foster care when she was two years old as a result of her mentally ill and chemically-dependent mother's neglect.[2] At the time of her removal, Desiree was reportedly a "normal" child.[3] Once placed, Desiree was moved numerous times—she had four foster home placements in five months, and was physically abused in two of the homes.[4] By the time she was in her fourth foster placement, Desiree's foster mother reported deteriorating behavior, including extreme temper tantrums.[5] By the age of three, Desiree began biting people and waking up crying at night.[6] Desiree's foster mother reportedly disciplined her by leaving her alone in her room for long periods of time, and preventing Desiree's older brother, whom Desiree viewed as a

2. *In re* Martin F. & Desiree L., 820 N.Y.S.2d 759, 760 (Fam. Ct. 2006).
3. *Id.* at 767.
4. *Id.* at 760, 767.
5. *Id.* at 765.
6. *Id.*

parental figure, from comforting her.[7] Although neither Desiree's play therapist nor day care provider could corroborate the tantrums and disruptive behavior, and although her play therapist was reducing the number of therapy sessions, Desiree was prescribed depakote sprinkles,[8] a psychotropic medication that is most commonly prescribed to treat manic symptoms and epilepsy.[9] Desiree's biological mother objected to the administration of the medication.[10] The mother was informed in writing that if she did not return a signed consent form for the depakote, "the Administrative Caseworker will sign and [Desiree] will be administered the medication" in one week.[11] The mother did not sign the consent form and, in accordance with the letter, a caseworker signed for the Department of Human Services (DHS) as the legal custodian to the child.[12] The caseworker who signed the override had not "reviewed the pediatric record or seen the child."[13]

The physician prescribing the depakote sprinkles testified at Desiree's permanency hearing[14] that although depakote was not FDA-approved for mood stabilization in children, it was "commonly used *on children ages 5 and up*."[15] Desiree was only three at the time. As side effects, the doctor identified sedation; stomachaches; dizziness; restlessness; irritability; diarrhea; tremors; hair loss; unusual bleeding or bruising; rash or hives with itching; allergies; impact on the liver, bone marrow, and pancreas; and death.[16] The doctor also noted that a child's blood levels, bone marrow, and liver functions must be checked every two weeks.[17] The doctor testified that he "knew the foster mother was too rigid and felt regulating the child's behavior with medication would be easier and maybe beneficial for Desiree rather than moving her to yet another foster home."[18]

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Lyle was four-and-a-half years old when he was placed in foster care.[19] His placement arose from allegations that he had been sexually and physically abused by people responsible for his care and that his young mother neglected him, medically and otherwise.[20] A few days after entering care, Lyle was observed drinking out of the

7. *Id.*

8. *Id.* at 765–66.

9. *See* PHYSICIANS' DESK REFERENCE 414 (62d ed. 2008) [hereinafter PDR] (describing indications and usages of Depakote ER, an alternative name for depakote sprinkles).

10. *Martin F. & Desiree L.*, 820 N.Y.S.2d at 760.

11. *Id.* at 767 (quoting letter from recommending physician).

12. *Id.*

13. *Id.* at 766.

14. At permanency hearings, held twelve months after a child enters foster care, the court determines what the permanent plan for a child should be, such as reunification with the parent, adoption, guardianship, or other permanent planned living arrangements. *See* Adoption and Safe Families Act of 1997, 42 U.S.C. § 675(5)(C) (2006).

15. *Martin F. & Desiree L.*, 820 N.Y.S.2d at 767.

16. *Id.* at 768.

17. *Id.*

18. *Id.* at 767.

19. *In re* Lyle A., 830 N.Y.S.2d 486, 487 (Fam. Ct. 2006).

20. When Lyle came into foster care, he suffered from ringworm, an infected toenail, and anemia. *Id.* at 487.

toilet, eating paper, and digging through the garbage.[21] Despite these behaviors, at the time of his removal Lyle was reported to be a "loving, nurturing, respectful and well-mannered" child.[22] Approximately two months after his placement in care, Lyle witnessed the sexual abuse of one foster sibling by another.[23] Although his foster parents had knowledge of the sexual abuse, they did not take action to protect the abused child.[24] After Lyle reported the abuse, the children at issue were removed but Lyle was kept in the same home.[25] A few weeks later, during a visit with his biological mother, Lyle disclosed that he, too, was being sexually abused.[26] Shortly thereafter, Lyle was moved to a new foster home where, according to DHS, his behavior began to deteriorate,[27] and where—for reasons that are unclear—DHS terminated visitation between Lyle and his aunt and grandmother.[28]

After six months in foster care, Lyle was diagnosed with post-traumatic stress disorder and explosive disorder.[29] He banged his head on the floor, exhibited suicidal ideation, and engaged in actions that could result in harm to himself and others.[30] Because of these behaviors, Lyle was seen by the physician in charge of the county foster care clinic.[31] After four visits, the physician prescribed Lyle depakote sprinkles.[32] Though the doctor provided a consent form for the medication, she did not meet with Lyle's biological mother.[33] The only information Lyle's biological mother received regarding the medication was orally conveyed by Lyle's caseworker.[34] When Lyle's biological mother stated that she did not believe that her son needed medication, the caseworker responded that "he would probably go to a 'residential facility' (*i.e.*, an institutional placement instead of an individual foster care home), if he did not go on the medication."[35] Lyle's mother took the consent form and spoke with various professionals, including a worker at the foster care clinic, who reportedly informed her that there were no side effects associated with depakote sprinkles.[36] To avoid another foster care placement, Lyle's mother signed the consent form despite her disbelief that

21. *Id.*

22. *Id.*

23. *Id.* at 487–88.

24. *Id.* at 488.

25. *Id.*

26. *Id.*

27. *Id.* Specifically, Lyle was reported as "acting out in [his] new foster care home, hit[ting] his siblings, and [being] disobedient." *Id.*

28. *Id.* Although the Department did not identify a reason for the cessation of visitation with these family members, the mother propounded that it was because the grandmother had authority over Lyle and gave Lyle structure. *See id.*

29. *Id.* at 488–89.

30. *Id.* at 489.

31. *Id.*

32. *Id.*

33. *Id.*

34. *Id.* at 489–91. Although the worker testified that she had a fact sheet regarding the depakote sprinkles, she did not provide—for reasons unexplained—that sheet to the mother. *Id.* at 491.

35. *Id.* at 489.

36. *Id.* at 489–90.

Lyle required the medication.[37] A few days later, after learning that depakote sprinkles could cause a stroke, the mother contacted the caseworker to ask that Lyle be taken off the drug.[38] The worker informed the mother that "she could not stop the medication as it had already been started."[39]

* * *

Prescriptions of psychotropic medications for children in the United States have exploded over the past decade. Between 1997 and 2007, the use of psychotropic medications by children in the general population increased sixfold.[40] Current data indicates that approximately four percent of children and adolescents in the general population receive psychotropic medications.[41] The prescription rates for children in foster care, however, indicate a far more alarming trend, with some studies finding that one-third, and up to fifty percent, of all children in care are prescribed one *or more* psychotropic medications at any given time.[42] These data suggest that epidemic numbers of children in foster care are taking psychotropics.[43] Despite this, the majority of states[44] have not taken meaningful steps to regulate psychotropic medications prescribed to children placed in their legal custody. The result is a deprivation of the opportunity for children in care to receive the least restrictive, and potentially most effective, mental health and behavioral treatment available as well as exposure to the potentially long-term and detrimental side effects associated with psychotropics. Against the backdrop of the woefully inadequate mental health care available to foster children,[45] the approach most states have taken regarding psychotropic medications suggests they have been managing—not treating—children in their care.

For two primary reasons, momentum finally appears to be shifting away from state complacency and towards regulations essential to controlling how psychotropic medications are prescribed. First, social science research about the manner and extent to which children in foster care are prescribed psychotropic medications has increased,

37. *Id.* at 490. The foster mother, who was present when the mother signed the form, reported that she was "just barely able to handle" Lyle at that point and encouraged the mother to sign the form. *Id.* at 491.

38. *Id.* at 490.

39. *Id.*

40. *Prescription Psychotropic Drug Use Among Children in Foster Care: Hearing Before the Subcomm. on Income Sec. and Family Support of the H. Comm. on Ways and Means*, 110th Cong. 11 (2008) (statement of Dr. Julie M. Zito, Ph.D., Professor of Pharmacy and Psychiatry, University of Maryland) [hereinafter Zito Testimony]; *see also* Angela Olivia Burton, *"They Use it Like Candy": How the Prescription of Psychotropic Drugs to State-Involved Children Violates International Law*, 35 BROOK. J. INT'L L. 453, 476–77 (2010) ("[P]ediatric psychopharmacotherapy in the United States increased dramatically during the late 1980s and throughout the 1990s.").

41. Ramesh Raghavan et al., *Interstate Variations in Psychotropic Medication Use Among a National Sample of Children in the Child Welfare System*, 15 CHILD MALTREATMENT 121, 121 (2010).

42. See *infra* Part II for a discussion of psychotropic medication use in foster child care.

43. Epidemic is defined as "affecting or tending to affect a disproportionately large number of individuals within a population, community, or region at the same time" or "excessively prevalent." *Epidemic Definition*, MERRIAM-WEBSTER.COM, http://www.merriam-webster.com/dictionary/epidemic (last visited Mar. 1, 2011).

44. See *infra* Part V.A for a discussion of psychotropic medication regulations and legislation that several states have enacted.

45. See *infra* Part III.A for a discussion of healthcare deficiencies within state foster care programs.

lending better transparency—albeit through limited data—regarding the disparately high rates of use by children in care.[46] Second, growing media coverage of high profile cases involving children in foster care receiving psychotropic medications at extremely young ages,[47] at extremely high rates,[48] or with devastating results has helped to raise awareness of the issue.[49] This increased awareness has led to calls from the child welfare and medical communities, including the Child Welfare League of America[50] and the American Academy of Child and Adolescent Psychiatry,[51] for meaningful regulation of prescription practices for children in foster care. State lawmakers are beginning to heed these calls. Indeed, a handful of states have passed legislation and promulgated rules specifically attempting to regulate how psychotropic medications are prescribed to children in their care.[52] And, in late 2008, Congress passed the Fostering Connections to Success and Increasing Adoptions Act of 2008 ("Fostering Connections Act"), broad federal legislation that, among other provisions, directs states to develop a coordinated strategy to respond to the mental health needs of children in foster care[53] and to develop plans that outline how prescriptions for psychotropic and other medications will be overseen.[54] Though these changes are encouraging, without broader policy shifts—including meaningful collaboration between child welfare and

46. See *infra* Parts II.A and II.B for a discussion of pertinent social science statistics relating to medications proscribed to children in foster care.

47. *See* Brent Walth & Michelle Cole, *Foster Kids' Meds Get Scant Attention*, OREGONIAN, Nov. 25, 2007, at A01 (describing a five-year-old boy being so heavily medicated with psychotropics that "he lived in an endless cycle of sleeping, rising for a meal, taking his pills and collapsing back into bed" and reporting that children in foster care as young as two are receiving "powerful psychiatric drugs" or receiving eight or more psychotropic drugs at a given time); *see also* CAROLE KEETON STRAYHORN, FOSTER CHILDREN: TEXAS HEALTH CARE CLAIMS STUDY—SPECIAL REPORT 111 (2006), *available at* http://www.window.state.tx.us/specialrpt/hccfoster06/hccfoster06_revised.pdf (finding that in 2004, 686 Texas foster children ages zero through four received "nearly 4,600 prescriptions for psychotropic medications").

48. *See* David Jackson, *Bipolar Cases Rise; Consent Is Bygone: Psychotropics Given to Wards Without State's OK*, CHI. TRIB., Dec. 10, 2009, at C16 ("Illinois has seen a steady increase in the number of state wards simultaneously prescribed four or more of the psychotropic medications . . . . During 2007, the most recent year when complete data were immediately available, more than 10 percent of Illinois wards given any psychotropic drug were taking four or more simultaneously . . . .").

49. *See* Carol Marbin Miller, *Child's Suicide Raises Questions About Medication*, MIAMI HERALD, Apr. 22, 2009, at 1A (reporting on suicide of seven-year-old foster child after being prescribed at least three psychotropic medications that were "not approved for use [by] young children" and which carried "'black box' label warnings for children's safety, the strongest advisory the federal agency issues").

50. *See generally* CHILD WELFARE LEAGUE OF AM., CWLA 2009 LEGISLATIVE AGENDA FOR CHILDREN AND FAMILIES 12–15 (2009), *available at* http://www.cwla.org/advocacy/2009legagenda.pdf.

51. *See generally* AMERICAN ACAD. OF CHILD AND ADOLESCENT PSYCHIATRISTS, AACAP POSITION STATEMENT ON OVERSIGHT OF PSYCHOTROPIC MEDICATION USE FOR CHILDREN IN STATE CUSTODY: A BEST PRINCIPLES GUIDELINE, http://www.aacap.org/galleries/PracticeInformation/FosterCare_BestPrinciples_FINAL.pdf (last visited Mar. 2, 2011) [hereinafter AACAP BEST PRINCIPLES] (setting forth minimal, recommended, and ideal standards for administration of psychotropic medications to children in care).

52. See *infra* Part V.A for a discussion of the psychotropic medication regulations and legislation that several states have enacted, including Connecticut, Florida, and Tennessee.

53. Fostering Connections to Success and Increasing Adoptions Act of 2008, Pub. L. No. 110-351, § 205, 122 Stat. 3949, 3961 (codified at 42 U.S.C. § 622(b)(15) (Supp. 2009)).

54. *Id.*

mental health agencies and more accessible and available mental health treatment—sustainability of this momentum is dubious, at best.

This Article explores the psychotropic-medication epidemic within the child welfare system. Following this Introduction, Part II provides an overview of psychotropic prescription patterns for children in foster care; it also identifies specific risks to children prescribed such medications. Part III looks both at and beyond children's mental health needs, to consider why psychotropic medications are prescribed to children in foster care at such high rates. In doing so, Part III explores specific child welfare policies (or failures thereof) that contribute to the increasing numbers of psychotropic prescriptions. Part IV explores the impact that existing federal child-welfare legislation has had on the mental health treatment provided to children in foster care and, in turn, on psychotropic prescription rates. Part IV also explores the health oversight and coordination provision of the Fostering Connections Act and its potential impact on state reliance on psychotropic medications. Finally, Part V reviews actions already taken by some states and offers tools and recommendations to assist others as they develop plans and create measurable systems of accountability to ensure that psychotropic medications are prescribed only in therapeutically appropriate and legally sound ways.

II. PSYCHOTROPIC MEDICATIONS AND CHILDREN IN FOSTER PLACEMENT: AN OVERVIEW

Children in foster placement receive psychotropic medications—drugs "that affect brain chemicals related to mood and behavior"[55]—at extremely high rates. Side effects from psychotropic medications can range from mild to severe, and include excessive sedation, liver damage,[56] significant weight gain and diabetes[57] as well as insomnia, decreased appetite, stomachaches, hypotension, constipation, tremors, headaches,

55. NAT'L INST. OF MENTAL HEALTH, U.S. DEP'T OF HEALTH AND HUMAN SERVS., TREATMENT OF CHILDREN WITH MENTAL ILLNESS 2 (rev. 2009) [hereinafter NIMH Report], *available at* http://www.nimh.nih.gov/health/publications/treatment-of-children-with-mental-illness-fact-sheet/nimh-treatment-children-mental-illness-faq.pdf. Definitions of psychotropic medication are provided in state statutes. *See* CAL. WELF. & INST. CODE § 739.5(d) (West 2010) ("Psychotropic medication or psychotropic drugs are those medications administered for the purpose of affecting the central nervous system to treat psychiatric disorders or illnesses. These medications include, but are not limited to, anxiolytic agents, antidepressants, mood stabilizers, antipsychotic medications, anti-Parkinson agents, hypnotics, medications for dementia, and psychostimulants."); OR. REV. STAT. § 418.517(5)(b) (2009) (defining psychotropic medications as "medication the prescribed intent of which is to affect or alter thought processes, mood or behavior, including but not limited to antipsychotic, antidepressant and anxiolytic medication and behavior medications. The classification of a medication depends upon its stated, intended effect when prescribed because it may have many different effects"); TEX. FAM. CODE ANN. § 261.111(a)(2009) ("'[P]sychotropic drug' means a substance that is: (1) used in the diagnosis, treatment, or prevention of a disease or as a component of a medication; and (2) intended to have an altering effect on perception, emotion, or behavior.").

56. Barbara J. Burns et al., *Effective Treatment for Mental Disorders in Children and Adolescents*, 2 CLINICAL CHILD & FAM. PSYCHOL. REV. 199, 213–16, 233 (1999).

57. *See* Kenneth E. Towbin, *Gaining: Pediatric Patients and Use of Atypical Antipsychotics*, 163 AM. J. PSYCHIATRY 2034, 2034–36 (2006) (noting that "significant weight gain" has been noted in fifty to sixty percent of children treated with certain types of psychotropic medications).

jitteriness, and seizures.[58] They may also be habit forming.[59] Psychotropic medications are divided into "classes" by the therapeutic benefit they provide. There are five major classes of psychotropic medications—antidepressants, antipsychotics, stimulants, mood-stabilizers, and antianxiety medications.[60] In 2004, a Pediatric Advisory Committee, organized by the Food and Drug Administration, found that there was a "causal link between [certain] antidepressants and pediatric suicidality."[61] One form of antidepressant called selective serotonin reuptake inhibitors, or SSRIs, carries a "black-box" warning on its labels because of its possible link to suicidal ideations or actions in children and young adults.[62] Children are "especially vulnerable to the adverse side-effects of psychotropic medications, some of which may be permanently debilitating and even fatal."[63] Within the context of these side effects and risks, this section explores the alarming prescription trends for foster children.

A. Prescription Paradigms

Children in foster placement, who by definition are eligible for Medicaid,[64] receive prescriptions for psychotropic medications at a rate three times higher than

58. *See, e.g.*, Burns et al., *supra* note 56, at 214–15. Although "[m]ost of the side effects are mild [and] reduce over time," some children have experienced cognitive impairments, tics, and psychosis while being treated with stimulants, while other children "cannot tolerate the side effects" and must discontinue the medications. *Id.* at 233.

59. *See* Gina Beltramo, *Everybody's Children*, 2 U.C. DAVIS J. JUV. L. & POL'Y 26, 27 (1997) (noting that Ritalin, the psychotropic "drug most people are familiar with," "may be habit forming"). The national consumption of Ritalin increased 600% between 1991 and 1997. *Id.*

60. NIMH Report, *supra* note 55, at 3.

61. Laurel K. Leslie et al., *The Food and Drug Administration's Deliberations on Antidepressant Use in Pediatric Patients*, 116 PEDIATRICS 195, 195 (2005).

62. *Id.* at 196, 200. A "black box" warning is "a statement in prominent, bold-faced type and framed by a black border." *Id.* at 195. By way of example, the black box warning on Paxil, an SSRI antidepressant, reads as follows:

> Antidepressants increased the risk of suicidal thinking and behavior (suidicality) in short-term studies in children and adolescents with Major Depressive Disorder (MDD) and other psychiatric disorders. Anyone considering the use of PAXIL or any other antidepressant in a child or adolescent must balance this risk with the clinical need. Patients who are started on therapy should be observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber. PAXIL is not approved for use in pediatric patients.

PDR, *supra* note 9, at 1529. SSRIs also can cause "anxiety, agitation, panic attacks, . . . irritability, hostility, aggressiveness, [and] impulsivity . . . ." PDR, *supra* note 9, at 1531. Children are "especially vulnerable to these adverse side-effects, some of which may be permanently debilitating and even fatal. *Id.*

63. Dennis E. Cichon, *Developing a Mental Health Code for Minors*, 13 T.M. COOLEY L. REV. 529, 605 (1996); *see also* DARCY E. GRUTTADARO & JOEL E. MILLER, NATION'S VOICE ON MENTAL ILLNESS, NAMI POLICY RESEARCH INSTITUTE TASK FORCE REPORT: CHILDREN AND PSYCHOTROPIC MEDICATIONS 6 (2004) ("The side effects common to some medications can be particularly difficult for children.").

64. Pursuant to 42 U.S.C. § 1396a (a)(10)(A)(i)(I) (2006), a state plan for medical assistance must make Medicaid available to "all individuals . . . who are receiving aid or assistance under any plan of the State" approved under Part E of Title IV. Title IV-E authorizes the funding source for states to receive federal monies for their foster care maintenance programs. 42 U.S.C. § 672.

other Medicaid-eligible youth.[65] Although there is exceedingly limited tracking done by states, and, therefore, limited information regarding the specific number of children in care prescribed psychotropics, existing data indicate that, on average, one-third of children in foster care receive one or more psychotropic drugs.[66] A 2003 Florida study found that twenty-eight percent of children (age thirteen and under) in foster care were prescribed at least one psychotropic medication, "including 550 children under the age of six."[67] In support of the prescription-medication provision of the Fostering Connections Act, discussed in Part IV.B *infra*, proponents cited to data collected by Dr. Julie Zito, a leading social science researcher of psychotropic medication use by foster children.[68] In 2004, Dr. Zito was commissioned by the State of Texas to study the rates of psychotropic use by children in foster care. Among other findings, Dr. Zito found that thirty-eight percent of all children in care were prescribed at least one psychotropic medication.[69] Other studies have found similar results.[70] With over 500,000 children in

65. Bonnie T. Zima et al., *Psychotropic Medication Use Among Children in Foster Care: Relationship to Severe Psychiatric Disorders*, 89 AM. J. PUB. HEALTH 1732, 1734 (1999) ("In comparison with a statewide sample of children aged 5 through 14 years enrolled in Medicaid, children in foster care were almost 3 times more likely to receive any psychotropic medication . . . ."); Julie M. Zito et al., *Psychotropic Medication Patterns Among Youth in Foster Care*, 121 PEDIATRICS e157, e161 (2008) (noting that although available literature is limited regarding prevalence of psychotropic drug use among foster children, the available data shows that "[c]ompared with nonfoster care Medicaid enrollees, psychotropic drug treatment in the foster care population . . . is 3.5– to fourfold more prevalent than in Medicaid-insured youth eligible by low family income").

66. *See Prescription Psychotropic Drug Use Among Children in Foster Care: Hearing Before the Subcomm. on Income Sec. and Family Support of the H. Comm. on Ways and Means*, 110th Cong. 43 (2008) (statement of Laurel K. Leslie, Developmental-Behavioral Pediatrician, Center on Child and Family Outcomes, Tufts-New England Medical Center Institute for Clinical Research and Health Policy Studies) [hereinafter Leslie Testimony] (noting that "[t]he few research studies available show rates of psychotropic medication use ranging from 13–50% among children in foster care"); *see also id.* at 24 (prepared statement of Tricia Lea, Ph.D., Director of Medical and Behavioral Services, Department of Children's Services, State of Tennessee) [hereinafter Lea Testimony] (noting that among foster children in Tennessee, in 2006, three percent of all four to six year olds, thirty-two percent of all seven to nine year olds, thirty-seven percent of all ten to twelve year olds, and thirty-three percent of all thirteen to eighteen year olds were administered one or more psychotropic medications); Zito Testimony, *supra* note 40, at 11 (noting that of three to sixteen year olds in Minnesota's Family Foster Care in 1998, thirty-four percent had at least one psychotropic medication prescription); CHILDREN & FAMILIES COMM., SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT, CS/CS/SB 1090 (Fla. 2005) ("25 percent of the children living in a foster care setting are being treated with psychotropic medications, a rate five times higher than that for the general population of Medicaid eligible children."); Raghavan et al., *supra* note 41, at 125 (noting that "California had the lowest percentage of children on medications," 5.7%, while "Pennsylvania had the highest," with 23.6% of children in care on medications); Zima et al., *supra* note 65, at 1734 ("[T]he proportions of children with the diagnoses of attention-deficit/hyperactivity disorder and major depression in [the sample of school-aged foster children studied] were conservatively twice as high as those reported among school-aged children in the community.").

67. CHILDREN & FAMILIES COMM., SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT, CS/CS/SB 1090 (Fla. 2005).

68. *See, e.g.*, *Prescription Psychotropic Drug Use Among Children in Foster Care: Hearing Before the Subcomm. on Income Sec. and Family Support of the H. Comm. on Ways and Means*, 110th Cong. (2008) (statement of Rep. Jim McDermott, Chairman, Subcomm. on Income Sec. and Family Support).

69. Zito Testimony, *supra* note 40, at 9 ("[I]n 2004, 38% of the 32,000+ Texas foster care youth less than 19 years of age received a psychotropic prescription.").

70. See *supra* notes 66–67 for a selection of studies presenting data on the use of psychotropic drugs by children in foster care.

foster care on any given day,[71] these data indicate that a substantial number of children are taking one or more psychotropic medications. The costs associated with prescriptions for psychotropic medications for foster children are also significant: Dr. Zito found that sixty percent of all prescriptions for children in foster care were for psychotropic medications, accounting for 76.5% of the costs of all medications prescribed to children in care, and totaling almost $30 million in one fiscal year.[72] Dr. Zito also found that antipsychotic medications, one class of psychotropics, accounted for thirty-eight percent of the total Medicaid expenditures for prescriptions for foster care youth.[73] A Connecticut study similarly found that forty-eight percent of all Medicaid spending on children's behavioral-health outpatient services, community-based services, and pharmaceuticals was for psychotropic drugs.[74]

B. Concomitant Rates of Use

Arguably the most alarming trend regarding psychotropic prescription patterns among children in foster care is the rate by which psychotropic drugs are prescribed concomitantly, or in combination. Dr. Zito's study of Texas foster children found that thirty-eight percent of all children in care were prescribed at least one psychotropic medication.[75] Of these children, seventy-three percent were prescribed two or more concomitantly, and forty percent received three or more psychotropic medications concomitantly.[76] Dr. Zito further found that approximately one in four children in foster placement with concomitant prescriptions had two or more *within* the same class.[77] For example, a child would be prescribed two or more antidepressants or two or more stimulants at the same time. Another study of children with Autism Spectrum Disorder (ASD) in foster care found that 20.8% of such children were prescribed *three or more* psychotropic medications concomitantly, as compared with only 10.1% of children on Supplemental Security Income who were classified as having ASD.[78]

71. As of September 2006, approximately 510,000 children were in foster care. ADMIN. FOR CHILDREN AND FAMILIES, U.S. DEP'T OF HEALTH & HUMAN SERVS., THE AFCARS REPORT 1 (2008), *available at* http://www.acf.hhs.gov/programs/cb/stats_research/afcars/tar/report14.pdf [hereinafter FOSTER CARE STATISTICS].

72. STRAYHORN, *supra* note 47, at 69.

73. *Id*. at vii.

74. *Id*. at 158.

75. Zito Testimony, *supra* note 40, at 9 ("[I]n 2004, 38% of the 32,000+ Texas foster care youth less than 19 years of age received a psychotropic prescription.").

76. *See id*. ("[W]e selected a one month cohort of youth in July 2004 and found 29% (n=429) received one or more classes of [psychotropic] medications. Of these psychotropic-medicated youth, 72.5% received two or more psychotropic medication classes and 41.3% received 3 or more such classes."). Also used in support of the Fostering Connections Act was testimony regarding Tennessee's review of its state's psychotropic prescription rate for foster children, which discovered that some children were taking as many as eight different psychotropic medications at one time. Lea Testimony, *supra* note 66, at 24.

77. Zito et al., *supra* note 65, at e157.

78. David M. Rubin et al., *State Variation in Psychotropic Medication Use by Foster Care Children with Autism Spectrum Disorder*, 124 PEDIATRICS e305, e305 (2009).

Prescribing two or more psychotropic medications at the same time is rationalized as necessary to treat different symptoms.[79] However, most combinations of psychotropic medications have not been proven effective or safe in remedying the underlying behavioral or mental health issues they are prescribed to address.[80] Combining medications at such high rates—particularly within classes—increases the risk of adverse drug interactions,[81] poses risk to the well-being of the child, and suggests that states are not monitoring how psychotropic medications are prescribed to children in care.

C. Off-Label Prescriptions and Inadequate Monitoring

The Food and Drug Administration (FDA) has approved almost all psychotropic medications as appropriate for administration to adults, not to children.[82] This lack of approval for use by children does not appear to have any real limiting effects on their use. Child psychiatrists and pediatricians routinely engage in the practice of prescribing psychotropic medications "off-label," that is, prescribing in a manner different from the intended or approved FDA use.[83] Between 45% and 75% of psychotropic medications given to children and adolescents are prescribed off-label.[84] The practice of off-label prescribing is a legal and accepted part of medical practice and is justified as an opportunity for relief that otherwise might not be available to a child.[85] However,

79. Daniel J. Safer et al., *Concomitant Psychotropic Medication for Youths*, 160 AM. J. PSYCHIATRY 438, 444 (2003).

80. *See* Zito et al., *supra* note 65, at e161–62 (noting high prevalence of non-FDA approved treatments among study population, and observing that medications approved for youth were seldom used). Indeed, in 2001, the American Academy of Child and Adolescent Psychiatrists issued a policy statement indicating that "[l]ittle data exist[s] to support advantageous efficacy for drug combinations, used primarily to treat co-morbid conditions. The current clinical 'state-of-the-art' supports judicious use of combined medications, keeping such use to clearly justifiable circumstances." *Prescribing Psychoactive Medication for Children and Adolescents*, AM. ACAD. OF CHILD & ADOLESCENT PSYCHIATRY, (Sept. 20, 2001), http://aacap.org/cs/root/policy_statements/prescribing_psychoactive_medication_for_children_and_adolescents.

81. Zito et al., *supra* note 65, at e162.

82. One reason that accounts for lack of FDA approval is the complex ethical issues surrounding conducting medical research on children, including issues relating to assent and permission. *See* Sheryl L. Buske, *Foster Children and Pediatric Clinical Trials: Access Without Protection Is Not Enough*, 14 VA. J. SOC. POL'Y & L. 253, 271 (2007) (noting that while support for including children in research studies is increasing, most drugs given to children have never been tested on them).

83. *See* Leslie et al., *supra* note 61, at 196 ("Off-label usage of many medications in pediatric populations ha[s] always been common and necessary, as most drugs ha[ve] not been studied adequately in children.").

84. *See* Michael W. Naylor et al., *Psychotropic Medication Management for Youth in State Care: Consent, Oversight, and Policy Considerations*, 86 CHILD WELFARE 175, 178 (2007) ("A review of the [Physician's Desk Reference] (2006) shows that approximately 45% of medications used for the treatment of emotional or behavioral disturbances in children or adolescents are off-label, having no approved use for patients under age 18."); Julie M. Zito et al., *Off-Label Psychopharmacologic Prescribing for Children: History Supports Close Clinical Monitoring*, 2 CHILD & ADOLESCENT PSYCHIATRY & MENTAL HEALTH 24, 24 (2008) (noting that up to seventy-five percent of all pediatric medications prescribed to children are done so off-label).

85. *See* Naylor et al., *supra* note 84, at 178 (noting that although off-label may be accepted standard of care, "[p]rescribers have the responsibility . . . to be well informed about the product, to base its off-label use

research suggests "very real differences in the absorption, distribution, metabolism, excretion, efficacy, and safety of some medications in children and adolescents compared with adults."[86] Additionally, the impact of psychotropic drugs on the developing brain, which continues to develop through young adulthood, is unknown.[87] For children in foster placement, there is the added concern that an involved, committed, and informed adult will not be available (or willing) to make an informed decision regarding whether the benefits associated with off-label use outweigh the risks, or to "advocate for alternatives to medication when behavioral problems are identified."[88] Indeed, as addressed in Part III.C *infra*, natural parents are not systematically given the opportunity to be informed and many care providers and caseworkers are not trained, nor have time, to seek alternatives to psychotropics.

Despite the foregoing risks, and the lack of clinically definitive data regarding safety, children in care who are prescribed one or more psychotropic medications often are provided little monitoring or follow-up care.[89] While monitoring the side effects of certain psychotropic medications can result in invasive procedures,[90] the absence of monitoring can place a child at great risk of harm. This harm is illustrated through facts alleged as part of a class action lawsuit filed in April 2010 on behalf of children in the legal custody of the Department of Family Services (DFS) in Clark County, Nevada.[91] The lawsuit alleges gross failures by DFS to provide necessary medical and mental health treatment to children in state care[92] and specifically identifies harms that befell children prescribed psychotropic medications: An eleven-year-old boy prescribed multiple psychotropics at one time fell gravely ill and "spent several weeks in the intensive care unit (ICU) of a hospital, and suffered near organ failure" due to the child

on firm scientific rationale and sound medical evidence, and to maintain records of the product's use and effects").

86. Leslie et al., *supra* note 61, at 196.

87. Christopher Bellonci & Tricia Henwood, Use of Psychotropic Medications in Child Welfare 9 (Powerpoint on file with author).

88. Rubin et al., *supra* note 78, at e310; *see also* STRAYHORN, *supra* note 47, at iii–iv (noting absence of engaged and active caregivers who have knowledge of foster children's medical history and medical needs). A study recently funded by the Food and Drug Administration (FDA) and the National Institute of Mental Health elucidates an additional reason why informed decision-making matters: on June 15, 2009, the FDA issued a news release stating that a recent study had found an association between stimulant medications, typically used for attention-deficit hyperactivity disorder, and "sudden cardiac death in healthy children." Press Release, Food & Drug Admin., FDA Issues Safety Communication About an Ongoing Review of Stimulant Medications Used in Children with ADHD, (June 15, 2009), *available at* http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/2009/ucm166616.htm. Although the FDA noted that the study had limitations and did not recommend that care providers cease providing the medications to children, the mere possibility speaks to why review by an informed adult matters. *Id.*

89. As explored further in Part III.A *infra*, reasons for the limited follow-up care range from insufficient community-based mental health resources to high caseloads that prevent caseworkers from facilitating appropriate medical attention.

90. *See, e.g.*, *In re* Martin F. & Desiree L., 820 N.Y.S.2d 759, 768 (Fam. Ct. 2006) (noting that monitoring side effects of patient's medication required doctor to monitor blood levels and check patient's bone marrow and kidney function every two weeks).

91. Complaint, Henry A. v. Willden, No. 2:10-CV-00528 (D. Nev. April 13, 2010) [hereinafter Henry Complaint].

92. *Id.* at 1–6.

welfare agency's failure to respond to his adverse reactions.[93] A nine-year-old girl prescribed psychotropic medications "without periodic reassessments of her psychological condition" sometimes waited for "eighteen months without a neuropsychological exam or reassessment while in [state] care."[94] And, a seven-year-old girl placed on multiple psychotropic medications was forced to go through "abrupt and painful withdrawal" after the child welfare agency responsible for her care failed to secure the child's medications when she entered a new placement.[95]

III. ACCOUNTING FOR RATES OF USE

At first glance, the prescription rates for psychotropic medications may appear consistent with the needs of children in foster placement. Data are unequivocal that children in state care are at an extremely high risk for mental health problems, both while in care and once out of it.[96] As compared to children from the same socioeconomic background, foster children "have much higher rates of serious emotional and behavioral problems, chronic physical disabilities, birth defects, developmental delays, and poor school achievement."[97] Studies suggest that as many as 80% of all children involved with the child welfare system have one or more issues requiring mental health intervention.[98] Despite these data, many observers of, and participants in, the child welfare system believe that the extent to which psychotropics are used neither fits the needs of foster children nor adequately attends to their mental health care. To meaningfully oversee the use of psychotropic medications, states first must evaluate what factors, outside of the documented needs of the foster population, may contribute to the epidemic rates of use. Within the framework of the deficient mental health services offered to children in care and to the providers who care for them, this section explores three factors that may account for the high rates of psychotropic medication prescriptions.

93. *Id*. at 7.

94. *Id.* at 10–11.

95. *Id.* at 23.

96. Even a child only temporarily removed from the care of her natural parents can "suffer economic, educational, and psychological hardship." Clare Huntington, *Rights Myopia in Child Welfare*, 53 UCLA L. REV. 637, 661 (2006). According to a recent study, "the rate of post-traumatic stress disorder (PTSD) among adults previously placed in foster care [is] twice as high as the incidence in combat veterans. In addition to PTSD, former foster care children suffer from depression, social phobia, panic syndrome, and anxiety disorders." *Id*. (footnotes omitted).

97. Comm. on Early Childhood, Adoption, and Dependent Care, Am. Acad. of Pediatrics, *Health Care of Young Children in Foster Care*, 109 PEDIATRICS 536, 536 (2002) [hereinafter AAP Policy Statement].

98. *See* ROB GEEN ET AL., THE URBAN INST., MEDICAID SPENDING ON FOSTER CHILDREN 1 (2005); *see also* DCF PSYCHOTROPIC MEDICATION ADVISORY COMM., DEP'T OF CHILDREN AND FAMILIES, STATE OF CONN., GUIDELINES FOR PSYCHOTROPIC MEDICATION USE IN CHILDREN AND ADOLESCENTS 7 (2010) [hereinafter CONNECTICUT GUIDELINES] ("Serious emotional disturbance, as defined by the presence of a diagnosable psychiatric condition and significant functional impairment, was present in 78 percent of the children in foster care." (referencing Elizabeth M.Z. Farmer et al., *Use of Mental Health Services by Youth in Contact with Social Services*, 75 SOC. SERV. REV. 605, 615 (2001))); Susan dosReis et al., *Mental Health Services for Youths in Foster Care and Disabled Youths*, 91 AM. J. PUB. HEALTH 1094, 1094 (2001) ("Research indicates that between 40% and 60% of youths in foster care have at least 1 psychiatric disorder, and approximately 33% have 3 or more diagnosed psychiatric problems.").

A. The Mental Health Care "Revolving Door"

On the most basic level, the medical and mental health needs of children in foster care are not being met. Children in care do not receive consistent dental,[99] medical,[100] or mental health[101] services, if they receive services at all, while in the legal custody of the state. In 2006, a national survey on child and adolescent well-being in foster care, prepared for the Casey Family Programs, found that "three out of four youth in child welfare who met stringent criterion for need were not receiving mental health care within 12 months after a child abuse and neglect investigation."[102] A 2008 audit of Nevada's child welfare system found that only forty-six percent of children with identified mental health needs receive mental health screenings.[103] That same audit found that "in 36% of the cases sampled," caseworkers "had made no concerted effort to address children's mental health needs."[104] Finally, although the vast majority of children in care are eligible for Medicaid,[105] and, as such, are entitled to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services,[106] the U.S. Government Accountability Office found that in 2007, only fifty-eight percent of all Medicaid children received at least one EPSDT check up for which they were eligible.[107]

The mental health treatment that is available to children in foster placement, at best, is fragmented. The American Academy of Pediatrics has characterized the care

99. *See* PUB. POLICY CTR., UNIV. OF IOWA, A STUDY OF IOWA'S CHILDREN IN FOSTER CARE 2 (2004), *available at* http://ir.uiowa.edu/cgi/viewcontent.cgi?article=1003&context=ppc_health (reporting that dental care for children in foster care was service area with "highest unmet need").

100. *See, e.g.*, AAP Policy Statement, *supra* note 97, at 536 (listing factors that contribute to poor health care services for foster children).

101. *See id.* ("Although a broad range of supportive and therapeutic services is needed, most children do not undergo a comprehensive developmental or psychological assessment at any time during their placement."); NEAL HALFON ET AL., UCLA CTR. FOR HEALTHIER CHILDREN, FAMILIES AND CMTYS., MENTAL HEALTH SERVICES FOR CHILDREN IN FOSTER CARE 1 (2002), *available at* http://www.healthychild.ucla.edu/PUBLICATIONS/ChildrenFosterCare/Documents/Mental%20health%20brief%20final%20for%20distribution.pdf [hereinafter UCLA Study] (noting that only 25% of children in foster care receive mental health services at any given time).

102. JOHN A. LANDSVERK ET AL., CASEY FAMILY PROGRAMS, MENTAL HEALTH CARE FOR CHILDREN AND ADOLESCENTS IN FOSTER CARE: REVIEW OF RESEARCH LITERATURE 2 (2006), *available at* http://www.casey.org/Resources/Publications/pdf/MentalHealthCareChildren.pdf.

103. Henry Complaint, *supra* note 91, at 29.

104. *Id.*

105. "All foster children for whom states receive federal reimbursement for foster care expenses (under title IV-E of the Social Security Act) are categorically eligible for Medicaid. States have the option to extend Medicaid benefits to non-IV-E eligible foster children, and all states do." GEEN ET AL., *supra* note 98, at 1; *see generally* 42 U.S.C. §§ 671–679 (2006).

106. *Overview of Medicaid Early & Periodic Screening & Diagnostic Treatment Benefit*, CTRS. FOR MEDICARE & MEDICAID SERVS., (Dec. 14, 2005, 12:00AM), http://www.cms.hhs.gov/medicaidearlyperiodicscrn. EPSDT authorizes the provision of medical screening to children eligible for Medicaid to cover "necessary health care, diagnostic services, treatment, and other measures . . . to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services." 42 U.S.C. § 1396d (r)(5) (2006).

107. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-09-578, MEDICAID PREVENTIVE SERVICES: CONCERTED EFFORTS NEEDED TO ENSURE BENEFICIARIES RECEIVE SERVICES 10 (2009).

provided as "often compromised by insufficient funding, poor planning, lack of access, prolonged waits for community-based medical and mental health services, and lack of coordination of services as well as poor communication among health and child welfare professionals."[108] There is, as noted by one physician, a "revolving door" of doctors, caseworkers and other adults providing the medical and mental health care to children in foster care[109] due to caseworker turnover,[110] high case loads,[111] and disruptions in stable living conditions experienced by children in care.[112] Indeed, in 2006, thirty-two state and local child welfare agencies expressed dissatisfaction with the level of mental health services available to children in state care.[113] Nevertheless, these deficiencies continue, as evidenced by numerous class action lawsuits filed around the country alleging both compromised and absent mental health services for foster children. A class action lawsuit filed against California's Department of Health Services alleged failures to provide "medically necessary mental health services in a home-like setting."[114] Specifically raised in the complaint were allegations that children with behavioral and emotional problems are "bounced between multiple foster placements and group homes that do not meet their individual needs; then, when their conditions predictably deteriorate, they are effectively abandoned by the system, [and] consigned to languish in psychiatric hospitals and secure congregate facilities."[115] A class action filed in Massachusetts alleging similar failures resulted in a ruling that Medicaid-eligible children with challenging mental health needs are entitled to "comprehensive assessments," developed with the participation of the children and their families, and to

108. AAP Policy Statement, *supra* note 97, at 536. Although "[s]everal researchers have documented poorer health and mental health status, less organized and comprehensive treatments, more discontinuity of care, and greater barriers to health services among youths in foster care," one study found that use of mental health services was, in fact, higher among Medicaid eligible youth in foster care than among other Medicaid eligible youth. dosReis et al., *supra* note 98, at 1094, 1097. The likely explanation for this is that a small number of children—those in residential treatment, group homes and psychiatric facilities—are using the vast majority of the funds. *See* Leslie Testimony, *supra* note 66, at 42 ("Children in foster care account for 25–41% of expenditures within the Medicaid program despite representing less than 3% of all enrollees.").

109. Press Release, American Academy of Pediatrics, Foster Children Need Better Coordinated Health Care to Ensure Appropriate Use of Psychotropic Medications (May 8, 2008), *available at* http://www.aap.org /advocacy/washing/News-Release_Press-Statements/05-08-08-Psychotropic.pdf.

110. *See* Buske, *supra* note 82, at 299 ("The turnover in child welfare staff is reported to be as high as 40% annually nationwide, and the average tenure of child welfare workers is less than two years.").

111. Deborah Weimer, *Beyond Parens Patriae: Assuring Timely, Informed, Compassionate Decisionmaking for HIV-Positive Children in Foster Care*, 46 U. MIAMI L. REV. 379, 383 (1991) (noting that caseworkers often carry caseloads that prohibit them from making their mandatory visits and from "obtaining even routine medical attention for children in their care").

112. *See* CASEY FAMILY PROGRAMS, FOSTER CARE BY THE NUMBERS 1 (2010), *available at* http://www.casey.org/Press/MediaKit/pdf/FosterCareByTheNumbers.pdf (reporting data from national survey which found that foster children experience an average of 3.2 placements per stay).

113. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-07-75, CHILD WELFARE: IMPROVING SOCIAL SERVICE PROGRAM, TRAINING, AND TECHNICAL ASSISTANCE INFORMATION WOULD HELP ADDRESS LONGSTANDING SERVICE-LEVEL AND WORKFORCE CHALLENGES 10, 11 fig. 2 (2006).

114. Katie A. v. Los Angeles Cnty., 481 F.3d 1150, 1152 (9th Cir. 2007).

115. First Amended Complaint for Declaratory and Injunctive Relief at 3, Katie A. v. Bontá, No. 02-056662 at 3 (C.D. Cal. Dec. 20, 2002).

receive case management and in-home behavioral support services.[116] Finally, as noted *supra*, a class action lawsuit currently pending against Nevada's largest county child welfare agency alleges pervasive failures to provide children in state care with necessary medical and mental health treatment.[117]

Given the prevalent mental health needs of children in foster care—including needs created by being placed within and moved around the child welfare system[118]—close collaboration between the child welfare and mental health systems is crucial to adequately respond to the "potentially deleterious" consequences of involvement with the child welfare system.[119] However, "such collaboration is not only atypical, it is relatively rare."[120] Reasons offered for barriers to collaboration are plentiful. They include overworked caseworkers without time to make referrals;[121] caseworkers untrained in or who perceive their role as not to include making referrals for mental health disorders;[122] mental health professionals untrained to deal with the significant mental health needs that children in care display;[123] and, perhaps most harmful, finger-pointing between the systems—that is, "different child-serving systems, based on funding issues, regulations, and expertise, [taking] the position that their particular system is not responsible but that another system should be accountable for the care of the child."[124] The level of collaboration that does exist between child welfare and mental health systems is often limited to contracts for front-end mental health services, such as screening and assessment,[125] with little collaboration beyond these initial services. Many mental health systems report that they "are not directly involved in setting policy and developing procedures for the assessment and treatment of children in foster care,"[126] with few indicating formal interaction with child welfare agencies, such as interagency task forces or financial or other collaboration on programs.[127]

116. Rosie D. v. Romney, 410 F. Supp. 2d 18, 52–53 (D. Mass. 2006).

117. *See* Henry Complaint, *supra* note 91, at 64–65 (alleging numerous failures by child welfare agency to provide proper medical treatment, services, and care).

118. *See* Theo Liebmann, *What's Missing from Foster Care Reform? The Need for Comprehensive, Realistic, and Compassionate Removal Standards*, 28 HAMLINE J. PUB. L. & POL'Y 141, 143, 148 (2006) (noting that removal standards "fail to account for the very real fact that removal from a parent carries proven risks of mental, emotional, and physical harm, including the development of separation anxiety, depression, and other mental health problems" and that children are abused in foster care at rates higher than rates outside of foster care system).

119. Lois A. Weithorn, *Envisioning Second-Order Change in America's Reponses to Troubled and Troublesome Youth*, 33 HOFSTRA L. REV. 1305, 1346–47 (2005).

120. *Id.*

121. Barbara J. Burns et al., *Mental Health Need and Access to Mental Health Services by Youths Involved with Child Welfare: A National Survey*, 43 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 960, 967 (2004).

122. *See id.* (expressing doubt that caseworkers believe it's their role to assess mental health problems and noting caseworkers' lack of mental health training).

123. *See id*. at 968 (noting shortage of child and adolescent psychiatrists).

124. John S. Lyons & Laura Rogers, *The U.S. Child Welfare System: A De Facto Public Behavioral Health Care System*, 43 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 971, 972 (2004).

125. HALFON ET AL., *supra* note 101, at 4.

126. *Id.* at 9.

127. *Id.* at 6.

Notwithstanding the impact this limited collaboration has on the mental health treatment provided to children in care, the effect that multiple placements has on both the mental health of, and the treatment provided to, a child in foster care cannot be overstated. Multiple placements disrupt a child's stability and security, and the trauma of multiple moves is often compounded by caseworker failure to provide a child's assessments, medication history, diagnoses (if any), and treatment records to the new treating physician and the new foster care provider.[128] "As a direct and foreseeable result, children routinely receive new and often conflicting diagnoses from their new doctors . . . ."[129] This in turn contributes to the overuse of psychotropic medications. As noted by Dr. David Rubin, researcher and pediatrician at the Children's Hospital of Pennsylvania:

> In practical terms, mental health professionals might perceive the suitability and efficacy of alternative behavioral interventions to be limited when children are frequently moving between homes or when they are likely to be under their care for only brief durations. Frequent moves between homes create treatment discontinuity or the potential for loss of or poor access to previous health information, which in turn can expose children to increasing combinations of medications or to their inappropriate administration or abrupt discontinuation.[130]

With limited options for follow-up treatment, limited communication between child welfare and mental health agencies, and insufficient funding for mental health services,[131] psychotropic medications are often the quickest and most available "treatment" for a foster child with mental health, behavioral, and emotional issues.[132] Prescribing medications within such a system, and without other therapeutic interventions, runs counter to the generally understood best medical practice that psychotropics "should not be used as the sole treatment for children with mental health disorders."[133] As noted by Carole Keeton Strayhorn—the Texas Comptroller who issued a 283-page report detailing gross failures in Texas' mental health care system

128. *Id.* at 31.

129. *Id.*

130. Rubin et al., *supra* note 78, at e310; *see also* Henry Complaint, *supra* note 91, at 31 (arguing that frequent movements of foster care placements can result in improper mental health care).

131. The primary funding mechanism for treatment (Medicaid) routinely provides inadequate reimbursement for needed health services. HALFON ET AL., *supra* note 101, at 1, 7. This is particularly true for mental health services, where seventy percent of mental health agencies and ninety-one percent of child welfare agencies report that Medicaid coverage is insufficient. *Id.*

132. See *supra* Part II for a discussion of psychotropic drugs and their use by foster care children.

133. Burton, *supra* note 40, at 467 n.58 (quoting CHILD WELFARE LEAGUE OF AM., STANDARDS OF EXCELLENCE FOR HEALTH CARE SERVICES FOR CHILDREN IN OUT-OF-HOME CARE 18 (Julie Gwin ed., rev. ed. 2007)) (internal quotation mark omitted); *see also Psychiatric Medication for Children and Adolescents Part I—How Medications Are Used*, FACTS FOR FAMS. (Am. Acad. of Child & Adolescent Psychiatry, D.C.), July 2004, at 1, *available at* http://www.aacap.org/page.ww?name=Psychiatric+Medication+For+Children+And+Adolescents+Part+I-How+Medications+Are+Used&section=Facts+for+Families [hereinafter *Psychiatric Medications for Children and Adolescents*] (noting that psychiatric medications should be used as part of a comprehensive treatment plan, which includes ongoing medical assessment and, usually, therapy).

for foster children—the failure to provide adequate and holistic mental health treatment results in "profound human suffering."[134]

B. Foster Care Provider Reimbursement Rates

Foster providers are paid by states to care for children through a combination of federal and state dollars,[135] though there is no federally required minimum rate of reimbursement.[136] Foster children can be placed in residential treatment facilities or group homes, with the vast majority placed in homes, either with relatives or strangers.[137] No "standardized calculation of exactly how much it costs to care for a child"[138] in a foster home existed until, in 2007, a collaborative project between the National Foster Parent Association, Children's Rights, and the University of Maryland School of Social Work considered the rates of foster care funding.[139] The project found that in almost every state in the country, foster care rates were "far below what is needed to provide basic care" for children,[140] and, on average, foster care rates would need to increase by thirty-six percent in order to meet the actual costs of providing care.[141]

Most states provide a higher rate of funding for foster children who have special needs—children with emotional, behavioral, or medical needs who require enhanced supervision, a high degree of structure, or other levels of intervention beyond basic care.[142] Criteria for determining special needs, or enhanced reimbursement rates, are determined state by state. Psychotropic medications appear to be one way of qualifying

134. STRAYHORN, *supra* note 47, at iii.

135. CHILDREN'S RIGHTS ET AL., HITTING THE M.A.R.C.: ESTABLISHING FOSTER CARE MINIMUM ADEQUATE RATES FOR CHILDREN 1 (2007), *available at* http://www.ssw.umaryland.edu/fostercare/MARC SummaryReport.pdf.

136. *Id.*

137. FOSTER CARE STATISTICS, *supra* note 71, at 1.

138. *Id.*

139. In order to meet the minimum adequate care rate for foster children, twenty-eight states would need to increase their foster care rates by 51% to 100% or more for one or more age groups. *Id.* at 7–9 tbl. 2.

140. *Id.* at 1.

141. *Id.* The estimated range went from no change in the District of Columbia to between 131% and 190% in Ohio, depending on the age of the child. *Id.* at 4–5 tbl. 1.

142. In the adoption context for purposes of determining reimbursement rates for parents adopting special needs children, the Adoption Assistance and Child Welfare Act defines a child as having special needs. when:

> (A) the State has determined that the child cannot or should not be returned to the home of his parents; and
>
> (B) the State had first determined (A) that there exists with respect to the child a specific factor or condition (such as his ethnic background, age, or membership in a minority or sibling group, or the presence of factors such as medical conditions or physical, mental, or emotional handicaps) because of which it is reasonable to conclude that such child cannot be placed with adoptive parents without providing adoption assistance . . . , and (B) that, except where it would be against the best interests of the child because of such factors as the existence of significant emotional ties with prospective adoptive parents while in the care of such parents as a foster child, a reasonable, but unsuccessful, effort has been made to place the child with appropriate adoptive parents without providing adoption assistance under this section . . . .

Adoption Assistance and Child Welfare Act of 1980, 42 U.S.C. § 673(c)(1) (2006).

for an enhanced rate of payment.[143] Although the collaborative project did not study the sufficiency of enhanced rates in meeting the needs of children in care, the difference between regular and enhanced reimbursement rates can be significant. A foster parent caring for a seven-year-old child in upstate New York with no special needs can receive $571 per month in foster care funds.[144] That same foster parent caring for a seven-year-old child with special needs receives $1,140.[145] In Oregon, a foster provider can receive, on top of the basic care rate, an added $212 to $850 per month given the needs of the child in their care.[146]

While this Article does not necessarily challenge the determination that a higher level of need and supervision warrants a higher level of reimbursement, it does consider the impact these reimbursement structures have on psychotropic medication prescriptions for children in care. Ultimately, responsibility for the care provided to a foster child rests with the child welfare agency with legal custody, and, by extension, to the caseworker assigned to work with that child. However, as discussed *supra*, overworked caseworkers often lack "the rudimentary knowledge, skills, or training needed to perform their job of ensuring the health, safety, and well being of foster children."[147] With natural parents either uninvolved or excluded[148] and with limited caseworker-to-child contact,[149] foster providers often supply much needed information to caseworkers and medical and mental health care providers regarding a child's behavior or mental health. Certainly the hope is that foster providers give accurate information regarding the children in their care. However, the current reimbursement systems may create a financial incentive for foster providers to describe concerns in a way that is likely to either obtain or maintain a prescription for a psychotropic medication when such a prescription is not, or is no longer, clinically appropriate for a child. Said differently, an unintended consequence of increasing reimbursement rates to foster providers who already are inadequately paid is that it may encourage mental health diagnoses and/or medication use. The augmented payments may be too crucial for foster providers to relinquish, even after a child has shown improved behavioral or mental health.[150]

Additionally, many in the child welfare community believe that children in foster care receive psychotropic medications at such high rates because a child may be easier

143. *See* STRAYHORN, *supra* note 47, at 157 (noting that a group home in California can receive "anywhere between $2,000 to $6,000-plus per foster youth, depending on how many medications they are on" (internal quotation mark omitted)).

144. *Maximum State Aid Rates for Rate Year (July 1, 2008 – June 30, 2009)*, N.Y. ST. OFF. OF CHILDREN & FAMILY SERVS., http://www.ocfs.state.ny.us/main/rates/FosterCare/Rates/FC-Board07-08.pdf (last visited Mar. 7, 2011).

145. *Id.*

146. OR. ADMIN. R. 413-090-0010(4) (2010).

147. Henry Complaint, *supra* note 91, at 3.

148. See *infra* Part III.C for a discussion of the lack of natural parent involvement.

149. See *supra* Part III.A for a discussion of the deficient relationship between caseworkers and foster children.

150. *See, e.g.*, Henry Complaint, *supra* note 91, at 35–36.

to manage when medicated.[151] Advocates fear, and anecdotal evidence supports, that some foster providers use psychotropic medications as a "chemical" restraint.[152] Once a child becomes easier to manage, there may be little incentive to seek less-invasive treatment options or remove a child from the medication, particularly where the options for follow-up treatment are scarce,[153] and given that foster providers often do not receive adequate information about, or an adequate level of training to care for, children placed in their care.[154] Many foster providers—specifically those untrained in alternative behavioral or in-home therapeutic options—may seek psychotropic medications for a child even in circumstances where that child could achieve equal, or superior, success through non-invasive therapies. States may ignore such practices because of limited treatment and training options available to foster care providers. States also may ignore such practices because of the insufficient number of foster homes to accommodate the half-million children in foster care every year: in 2004, there were over 500,000 children in state care, but only 153,000 licensed kinship and non-relative foster homes nationwide.[155] As a result, states must maintain the homes that exist. If a child on psychotropic medications is easier to manage while on medications and without such medications the placement may be jeopardized, there may be an incentive by both the state and the foster provider to allow, or ignore, the use of psychotropics in order to maintain the placement.[156]

C. Informed Consent and Natural Parents

1. Due Process

The rights that transfer from natural parents to the state after their child has been placed in the state's legal custody are generally well-defined. Most states define legal custody as including most of the following rights: the right to have physical possession of the child; the right and duty to protect, train, and discipline the child; and the

151. See *supra* note 56 and accompanying text for a discussion of sedation being a side effect of psychotropic medications.

152. *See* Henry Complaint, *supra* note 91, at 34 (alleging that child in custody of Nevada's child welfare agency often received five or six psychotropic medications at a given time, making child lethargic and unable to focus, "simply because a caregiver requested a 'fix' for her behavior, without proper consent and without an appropriate, comprehensive assessment by a qualified health professional"). Also, instead of treating a foster child with behavioral approaches, a psychiatrist prescribed drugs for ADHD "based on nothing more than the request of a foster mother who had only known [the child] for a matter of weeks." *Id.* at 35.

153. *See* Maggie Brandow, Note, *A Spoonful of Sugar Won't Help This Medicine Go Down: Psychotropic Drugs for Abused and Neglected Children*, 72 S. CAL. L. REV. 1151, 1162 (1999) (addressing states' willingness to medicate minors based on desire to not lose already scarce foster homes).

154. *See, e.g.*, OREGON DEP'T OF HUM. SERVS., OREGON FOSTER CARE SAFETY TEAM FINAL REPORT: FINDINGS AND RECOMMENDATIONS, *available at* http://www.oregon.gov/DHS/abuse/publicatons/children/fcst-finalreport.pdf?ga+t (last visited June 5, 2011).

155. *Quick Facts About Foster Care*, WELFARE LEAGUE OF AM., www.cwla.org/programs/fostercare /factsheet.htm (last visited Mar. 7, 2011). Children also can be placed in residential treatment centers or group homes.

156. *See In re* Martin F. & Desiree L., 820 N.Y.S.2d 759, 767 (Fam. Ct. 2006) (noting medical testimony that regulating foster child's behavior with medication was better than moving child to new foster home).

responsibility to provide the child with food, clothing, shelter, and education.[157] Many states also vest the legal custodian with the responsibility to provide the child with "ordinary medical care."[158] Although ordinary medical care is defined by only a few states,[159] "ordinary" is characterized as that which is "routine" or "usual."[160] Accordingly, despite an adjudication of abuse and neglect, until a court order indicates otherwise, or until their parental rights are terminated, natural parents retain the right to consent to anything beyond "ordinary" medical care.

Many types of medical and mental health treatment provided to children in foster care, such as immunizations, dental hygiene, or mental health assessments, present little risk that they are given for any other reason than because they are, in fact, clinically appropriate. However, despite the growing number of foster children prescribed psychotropic medications, for the reasons identified in Part II *supra*, psychotropics go beyond routine or usual care.[161] Accordingly, consent by the agency with legal custody, without more, is not legally sufficient to consent to the prescription of such medications. While some states may require parental consent for psychotropic medications,[162] in practice, this process often is either not being followed,[163] is being circumvented in ways that make a parent's consent, or lack thereof, immaterial to the determination of whether to provide the medication, or is simply subverted to the

157. For specific state definitions of "legal custody" in juvenile matters see, for example, ALA. CODE § 12-15-102(16) (2010); COLO. REV. STAT. § 19-1-103(73)(a) (2010); FLA. STAT. § 39.01(35) (2010); GA. CODE ANN. § 49-5-3(12) (2010); HAW. REV. STAT. § 571-2 (2010); 705 ILL. COMP. STAT. ANN. 405/1-3(9) (2009); LA. CHILD. CODE ANN. art. 116(12) (2009); ME. REV. STAT. tit. 15, § 3003(19) (2010); MONT. CODE ANN. § 41-5-103(29)(a) (2009); N.H. REV. STAT. ANN. § 169-C:3(XVII) (2010); 42 PA.CONS. STAT. ANN. § 6357 (West 2010); S.C. CODE ANN. § 63-7-20(13) (2010); TENN. CODE ANN. § 37-1-140(a) (2010); UTAH CODE ANN. § 78A-6-105(21) (West 2010); WYO. STAT. ANN. § 14-3-402(a)(x) (2009).

158. For specific state statutes referencing "ordinary medical care," see the statutes cited in *supra* note 157.

159. *See, e.g.*, DEL. CODE ANN. tit. 31, § 5101(6) (2009) (defining "ordinary medical care" as "medical treatment including surgical procedures and mental health treatment other than inpatient psychiatric hospitalization"); FLA. STAT. ANN. § 985.03(39) (West 2010) (expressly excluding provision of psychotropic medication from definition of "ordinary medical care"); ILL. ADMIN. CODE tit. 89, § 327.2 (2009) (defining "ordinary medical care" as "routine" medical procedures "which do not involve hospitalization, surgery, or use of anesthesia and include, but are not limited to inoculations, physical examinations, and remedial treatment for minor illnesses and injuries"); WYO. STAT. ANN. § 14-3-402(a)(xviii) (2009) (defining ordinary medical care as examinations, routine treatments, and emergency surgical procedures).

160. *Ordinary Definition*, MERRIAM-WEBSTER.COM, http://www.merriam-webster.com/dictionary/ordinary (last visited Mar. 2, 2011).

161. See *supra* Part II for a discussion of the harmful risks and side effects associated with psychotropic medications. *But see* N.M. STAT. ANN. § 32A-1-4(O) (Supp. 2009) (stating that "legal custody" includes authority to consent to "administration of legally prescribed psychotropic medications pursuant to the Children's Mental Health and Developmental Disabilities Act").

162. See *infra* Part V.A for a discussion of psychotropic medication regulations and legislations that states have enacted. *See also* Naylor et al., *supra* note 84, at 181 tbl. 1, 182 (identifying persons authorized to give consent in each state).

163. Prior to enacting regulations specifically identifying the rights of parents to be included in the consent process, a Tennessee study found that consent came from a natural parent in only thirty-three percent of all cases. *See* Bellonci & Henwood, *supra* note 87.

agency's "legal custody."[164] The failure to afford the natural parent whose child is in the state's legal custody a meaningful consent process increases the likelihood that psychotropics will be given.

The court addressed this latter point in the case of *In re Martin F. and Desiree L.*[165] In the case, the mother challenged DHS's assertion that because it had statutory authority to "give effective consent for medical, dental, health and hospital services" for abused and neglected children in its care, it had discretion in seeking the consent of the natural parent prior to obtaining Desiree's prescriptions.[166] The court disagreed, finding that because of the nature of the medications at issue, the DHS did not have the legal authority to consent over the mother's objection without first affording the mother due process.[167] Although the court noted that there were circumstances in which a state's *parens patriae* power might overcome a parent's wishes when objecting to specific medical treatment, the court found that in a non-life-threatening situation involving mental health medications, a "state may override the fundamental liberty interest in the parent-child relationship only when there is a sufficiently compelling state interest."[168] In reaching this conclusion, the court relied heavily on the U.S. Supreme Court decision in *Santosky v. Kramer*,[169] which held that "[t]he fundamental liberty interest of natural parents in the care, custody, and management of their child *does not evaporate simply because they have not been model parents or have lost temporary custody of their child to the State.*"[170] Given these protected interests, the court in *Martin F. & Desiree L.* specifically found:

> The current administrative consent process used by DHS violates the due process rights of parents because it gives them no real rights—only the opportunity to consent. It is more like a notice provision regarding a decision already made than an invitation to participate in the decision-making process. . . .
>
> Of course, a 3-year-old child by definition is incompetent to make his or her own medical decisions, and *even though a parent has lost the care and custody of his or her children due to neglect, he or she still retains his or her constitutional right (i.e., liberty interest) to the management of important medical decisions for those children.* . . . In cases where a parent objects, the decisive question must be whether the medication *should* be administered to the child under the *parens patriae* power.[171]

Based on the foregoing, the court held that the standard to apply when determining whether to provide psychotropic medications to a child after the parent objects is

164. See *supra* notes 2–39 and accompanying text for a background discussion of consent procedures and facts in *In re Martin F. & Desiree L.* and *In re Lyle A.*

165. 820 N.Y.S.2d 759 (Fam. Ct. 2006).

166. *Martin F. & Desiree L.*, 820 N.Y.S.2d at 762 (emphasis removed) (quoting N.Y. SOC. SERV. LAW § 383-b (Consol. 2006)).

167. *Id.* at 771–72.

168. *Id.* at 770 (quoting M.N. v. S. Baptist Hosp. of Fla., 648 So.2d 769, 770–71 (Fla. Dist. Ct. App. 1994)).

169. 455 U.S. 745.

170. *Id.* at 753 (emphasis added).

171. *Martin F. & Desiree L.*, 820 N.Y.S.2d at 771–72 (first emphasis added).

similar to the standard that applies in cases where the state seeks to forcibly medicate an objecting adult:

> [I]f the parent of a child in foster care opposes the administration of mental health medicine it cannot lawfully be prescribed unless the court determines, after a hearing *de novo* with counsel, whether the proposed treatment by medication is narrowly tailored to give substantive effect to the child patient's liberty interest, "taking into consideration all relevant circumstances, *including the child patient's best interests, the benefits to be gained from the treatment, the adverse side effects associated with the treatment and any less intrusive* alternative treatments."[172]

Relying on the holding in *Martin F. & Desiree L.*, the court in *In re Lyle A.*[173] similarly found that when Lyle's mother asked to stop the medication, the DHS "promptly should determine its position anew and either honor the withdrawal of consent by the parent or seek a court order."[174]

Even when a natural parent is given an opportunity to consent to the appropriateness of a psychotropic medication for her child, and is either unable or unwilling to do so, a lack of consent often is followed by an expectation of approval by the child welfare agency. A recent case from the District of Columbia Court of Appeals, *In re G.K.*,[175] elucidates this point. G.K. was a child diagnosed with Bipolar Disorder, ADHD, and Oppositional Defiant Disorder after being placed in foster care.[176] G.K.'s mother was contacted to determine whether she would consent to the administration of psychotropic medications for her child.[177] The mother refused, reportedly stating that "'God will heal him' and that 'he just needs his mother to get better.'"[178] After an emergency hearing, the trial judge found that parents of neglected children do not retain constitutional or statutory rights to make medical decisions after their child has been committed to the child welfare agency's legal custody.[179] The judge ordered the Director of the child welfare agency to "'either delegate someone in [the child welfare agency] or maintain the role himself to make medication decisions, after hearing from doctors as to what medications are medically appropriate.'"[180]

The District of Columbia Court of Appeals overturned the trial court's ruling,[181] holding, in part, that "the trial court erred in delegating to [the child welfare agency] the ultimate responsibility to make decisions about whether it was in G.K.'s best interest to continue taking his psychotropic medications."[182] The court noted that the child welfare agency "does not have the statutory authority to make decisions about

172. *Id.* at 772 (quoting Rivers v. Katz, 495 N.E.2d 337, 344 (N.Y. 1986)).

173. 830 N.Y.S.2d 486, 494 (Fam. Ct. 2006).

174. *Lyle*, 830 N.Y.S.2d at 494.

175. 993 A.2d 558 (D.C. 2010).

176. *G.K.*, 993 A.2d at 560.

177. *Id.* at 562.

178. *Id.*

179. *Id.* at 562–63.

180. *Id.* at 563.

181. *Id.* at 570.

182. *Id.*

non-emergency psychotropic medication for children in its legal custody,"[183] since such authority is among the residual rights natural parents retain.[184] In order to exercise its discretion to overrule a parent's prerogative, the trial court must first find "by clear and convincing evidence that doing so would be in the best interests of the child."[185] Put differently, the appellate court's message to the lower court judge is that rubber stamping the agency's request is not sufficient.

2. Practical Benefit

When there is no danger to the child and where reunification is the permanent plan, involving natural parents in determining the appropriateness of psychotropic medications for their children makes practical sense for two additional reasons. First, with natural parents excluded, or deprived of an opportunity to dissent, the agency is less accountable. Diminished accountability creates less incentive to question the need for medication, or to explore alternative or contemporaneous treatment. Including parents to the extent possible forces an additional check on a system that has become complacent about psychotropic medication use. Of course, even if the mothers in Lyle's, Desiree's, and G.K.'s cases were given the due process to which they were entitled, the medications may still have been provided or maintained over their objections.[186] However, the administration of the medications would have occurred—theoretically—after a court hearing thoroughly vetted the risks and benefits.[187]

Second, children are returned to the care of their parents or other primary caregivers in over fifty percent of all child welfare cases.[188] Reunifications occur more commonly when parents, in addition to addressing their own issues, are involved in the lives of their children.[189] By meaningfully including natural parents in the decision-making process, states not only benefit from an additional set of eyes on the child's needs, but also empower parents to parent—to assess risks and benefits, to develop an understanding of their children's mental health needs, and to make decisions regarding their children. Inclusion of natural parents in this way pursues a noted goal of the child welfare system: to provide services to families who need assistance in order to care for their children and, ultimately, to achieve successful reunification of families where possible. Allowing a parent to parent to the extent that she is able is consistent with that goal.

183. *Id.*

184. *Id.*

185. *Id.*

186. See *supra* notes 165–85 and accompanying text for an analysis of Lyle's, Desiree's, and G.K.'s cases.

187. *See, e.g.*, *In re* Martin F. & Desiree L., 820 N.Y.S.2d 759, 772 (Fam. Ct. 2006) (ruling that de novo hearing is required if parent objects to administration of psychotropic drug).

188. FOSTER CARE STATISTICS, *supra* note 71, at 4.

189. Susan Dougherty, *Promising Practices in Reunification*, PERMANENCY PLANNING TODAY (Nat'l Res. Ctr. for Foster Care & Permanency Planning, New York, N.Y.), Spring 2004, at 12.

IV. FEDERAL LEGISLATION, MENTAL HEALTH, AND PSYCHOTROPIC MEDICATIONS

In 1974, Congress passed the Child Abuse Prevention and Treatment Act (CAPTA), the first federal legislation to outline provisions for protecting children from abuse and neglect.[190] Neither CAPTA nor the child welfare legislation enacted over the next three decades directed specific requirements for the health care provided to children while in the child welfare system. This section considers the impact that this failure has had on the psychotropic medication epidemic, and the hopeful promise that the 2008 Fostering Connections Act provides.

A. Reasonable Efforts and Mental Health

Six years after the passage of CAPTA, Congress passed the Adoption Assistance and Child Welfare Act (AACWA).[191] AACWA attempted to respond to the significant number of children in foster care, as well as the problem of "foster care drift"—a situation where children wait "sometimes for their entire childhoods, for the child protection agency to decide whether they should be reunited with their parents or whether alternative permanent plans should be implemented."[192] AACWA was the first federal legislation to include a specific mandate that in each dependency case, "reasonable efforts" should be made "prior to the placement of a child in foster care . . . to prevent or eliminate the need for removing the child from the child's home" and also "to make it possible for a child to safely return . . . home."[193] The goal of AACWA and the reasonable efforts requirement was to emphasize family preservation and reunification.[194] Despite this goal, and despite initial reductions, by the late 1990s the number of children in care had reached over half a million,[195] reinstating concerns about foster care drift. Critics of AACWA voiced concern that excessive efforts were being made towards reunification, even when reunification may not be safe, thereby prolonging the amount of time children were spending in foster care and preventing movement towards an alternative permanent plan.[196] Moreover, although AACWA provided that state child welfare services shall include "*protecting and promoting the welfare of all children*, including handicapped, homeless, dependent, or neglected children"[197] and "*assuring adequate care of children away from their homes*, in cases where the child cannot be returned home or cannot be placed for adoption,"[198] AACWA does not impose specific requirements or incentives for states to attend to the mental or medical health treatment provided to children in foster care.

190. 42 U.S.C. §§ 5101–5116 (2006).

191. Adoption Assistance and Child Welfare Act of 1980, Pub. L. No. 96-272, 94 Stat. 500 (codified as amended in scattered sections of 42 U.S.C.).

192. Kathleen S. Bean, *Reasonable Efforts: What State Courts Think*, 36 U. TOL. L. REV. 321, 324–25 (2005).

193. 42 U.S.C. § 671(a)(15) (1983) (current version at 42 U.S.C. §671(a)(15)(B)(i)–(ii) (2006)).

194. Bean, *supra* note 192, at 325.

195. *Id.* at 325–26.

196. *Id.* at 326.

197. Adoption Assistance and Child Welfare Act of 1980, Pub. L. No. 96-272, § 103, 94 Stat. 519 (codified as amended at 42 U.S.C. § 625(a)(1) (2006)) (emphasis added).

198. *Id.* (emphasis added).

In response to the concerns of foster care drift and unsafe reunifications raised by AACWA, Congress passed the Adoption and Safe Families Act of 1997 (ASFA).[199] The primary goal of ASFA was to increase permanency and safety for children in foster care.[200] ASFA mandates that, with limited exception, the state must move to terminate parental rights if a child has been in foster care for fifteen out of the previous twenty-two months.[201] ASFA modified AACWA's reasonable efforts mandate to include that reasonable efforts also include reasonable efforts "to place a child . . . in accordance with [another] permanency plan."[202]

While ASFA has been praised for providing more certainty regarding timelines for permanency,[203] it also has been criticized for overemphasizing removal of children from their homes, for promoting adoption at the expense of family preservation and reunification,[204] and for the disparate impact its fifteen-month timeline has on poor—often minority—families.[205] This Article offers an additional critique: Although ASFA states that a "child's health and safety shall be the paramount concern,"[206] its statutory framework confirms that health and safety are contemplated in the context of determining placement and permanency planning, and not in the context of the health and safety of children once they have been placed in the child welfare system. Accordingly, despite the extremely high rates of behavioral, emotional, and psychological problems experienced by children in care,[207] when those needs do not impact reunification with a parent or other permanent plans, ASFA offers little incentive to prioritize longer-term health treatment solutions. ASFA's emphasis on

199. Adoption and Safe Families Act of 1997, Pub. L. No. 105-89, 111 Stat. 2115 (codified as amended in scattered sections of 42 U.S.C.).

200. *Id.*

201. 42 U.S.C. § 675(5)(E) (2006). A state may be exempted from this requirement if the child is in the care of a relative, a "compelling reason" exists for determining that it would not be in the child's best interests, or the agency has failed to provide reasonable efforts to the parent. *Id.* § 675(5)(E)(i)–(iii).

202. *Id.* § 671(a)(15)(C). ASFA also identifies circumstances where states are not required to provide services aimed at reunification, including where a parent has murdered one of his/her children, committed voluntary manslaughter against of one of his/her children, or subjected the child to "aggravated circumstances." *Id.* § 671(a)(15)(D).

203. Elizabeth Bartholet, *The Racial Disproportionality Movement in Child Welfare: False Facts and Dangerous Directions*, 51 ARIZ. L. REV. 871, 889–90 (2009).

204. *See* Annette R. Appell, *Virtual Mothers and the Meaning of Parenthood*, 34 U. MICH. J.L. REFORM 683, 729 (2001) (arguing that AFSA limits resources for family preservation and reunification while promoting adoption); Jeanne M. Kaiser, *Finding a Reasonable Way to Enforce the Reasonable Efforts Requirement in Child Protection Cases*, 7 RUTGERS J.L. & PUB. POL'Y 100, 108–09 (2009) (arguing that focusing reasonable efforts requirement on health and safety of children limits resources dedicated to preserving family); *see also* Amy Wilkinson-Hagen, Note, *The Adoption and Safe Families Act of 1997: A Collision of Parens Patriae and Parents' Constitutional Rights*, 11 GEO. J. ON POVERTY L. & POL'Y 137, 140 (2004) ("ASFA tilts *away* from parental rights because it creates strict time frames regarding when termination hearings will begin and provides incentive funds to states that achieve permanency through adoption into new families, while offering *no* such funding incentives for permanency achieved through reunification efforts with biological families.").

205. *See* DOROTHY ROBERTS, SHATTERED BONDS: THE COLOR OF CHILD WELFARE 105 (2002) (discussing ASFA and its negative impact on black family preservation).

206. *Id.* § 671(15)(A).

207. See *supra* notes 96–98 and accompanying text for a discussion of the high rate of mental health problems among foster children.

"reasonable efforts,"[208] permanency planning, and the significant financial incentives it ties to these efforts, results in "secondary" services—services such as those needed to obtain an adequate level of mental health treatment—being overlooked. Instead, the minimal efforts needed to obtain a psychotropic prescription may be overly relied upon by caseworkers seeking a finding that reasonable efforts towards a child's permanent plan were made.

Child welfare agencies are not, nor should they be expected to be, mental health service providers. And making efforts to achieve permanency for a child is not, by itself, problematic. However, given the documented needs of children in care, balancing the efforts made towards achieving permanency with those necessary to ensure the health and safety of children while in the child welfare system is long overdue.

B. The Fostering Connections Act of 2008

In 2008, the Fostering Connections Act was signed into law.[209] The Act imposes significant child welfare reform- and legislative-agendas on states and includes provisions ranging from enhanced financial support for relative caretakers,[210] to promotion of sibling co-placement and visitation,[211] to improved incentives for adoption, to increased services to foster children for independent living services.[212] The Act also is the first federal legislation to set out specific provisions for the mental health and medical care provided to children in state custody, filling the void left by ASFA and its predecessors.[213] The Act specifically mandates collaboration with "pediatricians [and] other experts in health care" and requires that states develop "a plan for the ongoing oversight and coordination of health care services for any child in a foster care placement, *which shall ensure a coordinated strategy to identify and respond to the health care needs of children in foster care placements*, including *mental health* and dental health needs."[214]

This mandated collaboration "shall include" an outline of, among other things:

> (i) a schedule for initial and follow-up health screenings that meet reasonable standards of medical practice;
>
> (ii) how health needs identified through screenings will be monitored and treated;
>
> (iii) how medical information for children in care will be updated and appropriately shared, which may include the development and implementation of an electronic health record;

208. See *supra* notes 193–94 and accompanying text for a discussion of "reasonable efforts" requirements under federal law.

209. Fostering Connections to Success and Increasing Adoptions Act of 2008, Pub. L. No. 110-351, 122 Stat. 3949 (codified as amended in scattered sections of 42 U.S.C.).

210. *Id.* § 101.

211. *Id.*

212. *Id.* § 401.

213. *See id.* § 205.

214. *Id.* (emphasis added).

> (iv) steps to ensure continuity of health care services, which may include the establishment of a medical home for every child in care;
>
> . . . and
>
> (vi) how the State actively consults with and involves physicians or other appropriate medical or non-medical professionals in assessing the health and well-being of children in foster care and in determining appropriate medical treatment for the children.[215]

The Act also requires that the mandated collaboration result in a plan for the "oversight of prescription medicines."[216]

The Fostering Connections Act has legislated what previous child welfare federal legislation has not—specific, prescriptive expectations for the medical and mental health care provided by child welfare agencies. Although still in its relative infancy, the Act's impact on the health needs of children in care has the potential to be considerable, particularly given how underserved those needs currently are. Requiring states to develop plans for the oversight of prescription medications offers an important step towards implementation of policies and actionable steps regulating psychotropic medication use. However, unlike other provisions of the Fostering Connections Act,[217] there are no direct financial incentives tied to the prescription medication provision.[218] Although the medication provision is required under Title IV-E of the Social Security Act and, as such, the federal government could penalize a state for lack of compliance,[219] without direct financial incentives states have less incentive to prioritize that provision, particularly where direct financial incentives exist for other provisions of the same Act. Indeed, a review of state legislation pending or approved in response to the Fostering Connections Act shows that only one – Georgia – has legislation pending specifically responsive to the prescription medication provision.[220] As it currently stands, therefore, the health care oversight provision may not reach its full potential for promoting meaningful change. Nevertheless, the Fostering Connections Act—whose true impact remains to be seen—offers a hopeful promise for improvement of the mental health care available to dependent children, and the first real opportunity to demand accountability for the way psychotropic medications are provided to children in care.

V. LOOKING AHEAD: WHERE DO STATES GO FROM HERE (AND WHERE HAVE THEY ALREADY GONE)?

A handful of states have taken steps to specifically regulate psychotropic medication use by children in their legal custody. This section explores those policies, and makes recommendations to inform the efforts of other states as they embark on the

215. *Id.*

216. *Id.*

217. *See, e.g.*, *id.* § 102 (offering grants to help "children who are in, or at risk of entering, foster care reconnect with family members").

218. *Id.* § 205.

219. 45 C.F.R. § 1355.33 (2009).

220. *Fostering Connections to Success and Increasing Adoptions Act of 2008*, NAT'L CONF. OF STATE LEGISLATURES, http://www.ncsl.org/default.aspx?tabid=22222 (last visited June 12, 2011).

process of outlining plans to effectively regulate psychotropic medication prescriptions for children in foster care.

A. Consent Process

In order to meaningfully regulate how psychotropic medications are prescribed to children in care, assessment of the appropriateness of the medications is needed. For the reasons identified in Part III *supra*, a process with clearly defined consent procedures is imperative for that assessment to occur. Florida,[221] California,[222] Illinois,[223] Oregon,[224] Connecticut,[225] and Tennessee[226] are a few states that have instituted consent practices for psychotropic medication prescriptions for children in care. This section explores a sample of the consent practices from some of these states.

Both Florida and Tennessee have specific policies regarding the administration of psychotropic medications generally, and how parents are included in the consent process, specifically. In response to the rampant use of psychotropics, Florida passed legislation regulating psychotropic medications for children in the state's legal custody prior to the passage of the Fostering Connections Act.[227] Florida specifically mandates that before the Department of Children and Family Services (DCFS) can provide psychotropic medications to a child in the legal custody of the state, the physician prescribing the medication must attempt to obtain informed consent from the child's parent or legal guardian.[228] DCFS is statutorily required to assist in this process by attempting "to invite the parent or legal guardian to the doctor's appointment and to offer them transportation to the appointment, if necessary";[229] attempting to contact the "parent or legal guardian as soon as possible upon learning of the recommendation for psychotropic medication by the prescribing physician and provid[ing] specific information to them on how and when to contact the physician";[230] and facilitating "transportation arrangements to the appointment and/or telephone calls between the parent or legal guardian and the prescribing

221. FLA. STAT. ANN. § 39.407(3)(a)(1) (West 2010).

222. CAL. WELF. & INST. CODE § 739.5(a) (West 2008).

223. Naylor et al., *supra* note 84, at 182.

224. OR. ADMIN. R. 413-070-0430 (2010).

225. CONNECTICUT GUIDELINES, *supra* note 98.

226. TENN. DEPT. OF CHILDREN'S SERVS., ADMINISTRATIVE POLICIES AND PROCEDURES: 20.24 (2010), *available at* http://www.tn.gov/youth/dcsguide/policies/chap20/20.24.pdf ("When the need for psychotropic medication arises, the parent(s) should be engaged in all medication decisions . . . , unless parental rights have been terminated . . . .").

227. FLA. STAT. ANN. § 39.407(3) (effective July 1, 2006, almost two full years before the Fostering Connections Act). In support of this legislation, the Health and Human Services Appropriations Committee of the Florida Senate cited a study that found "25 percent of the children living in a foster care setting were being treated with psychotropic medications, a rate five times higher than the general population of Medicaid eligible children." HEALTH AND HUMAN SERVS. APPROPRIATIONS COMM., SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT, CS/CS/SB 1090 (Fla. 2005).

228. FLA. STAT. ANN. § 39.407(3)(a)(1) (West 2010).

229. FLA. ADMIN. CODE ANN. r. 65C-35.003(4)(a) (2010) (interpreting FLA. STAT. ANN. § 39.407(3) (2010) for the Florida Department of Children and Family Services).

230. *Id.* r. 65C-35.003(4)(b).

physician."[231] When express and informed consent from a child's parent cannot be obtained, when the parent refuses to give consent, or when the parent's parental rights have been terminated, DCFS may, after consultation with the prescribing physician, move the court to authorize the prescription of a psychotropic medication to the child.[232] A motion to authorize the medication must include the efforts made by DCFS to contact the parents; the nature and purpose of the treatment; the side effects of the medication; and any additional behavioral, counseling or other services recommended by the prescribing physician.[233] A hearing will be set if a party objects within two working days of receipt of DCFS's motion.[234]

Tennessee similarly requires that prior to the administration of a psychotropic medication to a child in the state's legal custody, parents will be notified of psychiatric appointments, will be requested to participate in person or by phone for consultation at the time of the appointment, and will be provided an opportunity to consent or refuse the administration of the medication.[235] If a parent is unable or unwilling to consent, Tennessee's child welfare agency, the Department of Children's Services (DCS), will honor that refusal, and only override it if the child will be harmed by not taking the

231. *Id.* r. 65C-35.003(4)(c).

232. FLA. STAT. ANN. § 39.407(3)(a)(1).

233. *Id.* § 39.407(3)(c)(1)–(5). According to the statute:

> The motion must be supported by a written report prepared by the department which describes the efforts made to enable the prescribing physician to obtain express and informed consent for providing the medication to the child and other treatments considered or recommended for the child. In addition, the motion must be supported by the prescribing physician's signed medical report providing:
>
> 1. The name of the child, the name and range of the dosage of the psychotropic medication, and that there is a need to prescribe psychotropic medication to the child based upon a diagnosed condition for which such medication is being prescribed.
>
> 2. A statement indicating that the physician has reviewed all medical information concerning the child which has been provided.
>
> 3. A statement indicating that the psychotropic medication, at its prescribed dosage, is appropriate for treating the child's diagnosed medical condition, as well as the behaviors and symptoms the medication, at its prescribed dosage, is expected to address.
>
> 4. An explanation of the nature and purpose of the treatment; the recognized side effects, risks, and contraindications of the medication; drug-interaction precautions; the possible effects of stopping the medication; and how the treatment will be monitored, followed by a statement indicating that this explanation was provided to the child if age appropriate and to the child's caregiver.
>
> 5. Documentation addressing whether the psychotropic medication will replace or supplement any other currently prescribed medications or treatments; the length of time the child is expected to be taking the medication; and any additional medical, mental health, behavioral, counseling, or other services that the prescribing physician recommends.

Id.

234. FLA. R. JUV. P. 8.355(a)–(b).

235. *See* TENN. DEPT. OF CHILDREN'S SERVS., ADMINISTRATIVE POLICIES AND PROCEDURES: 20.24 (2010), *available at* http://www.tn.gov/youth/dcsguide/policies/chap20/20.24.pdf (detailing procedures for engaging families in informed consent); TENN. DEPT. OF CHILDREN'S SERVS., ADMINISTRATIVE POLICIES AND PROCEDURES: 20.18(D) (2008), *available at* http://www.tn.gov/youth/dcsguide/policies/chap20/20.18.pdf (indicating that informed consent must be obtained for children in custody of Department of Children's Services prior to receiving psychotropic medication).

medication.[236] For purposes of determining the appropriateness of the medication, Tennessee has a nurse practitioner and psychiatrist on staff in the child welfare agency's central office who must be consulted before beginning a child on a psychotropic medication.[237] If DCS determines that the medication is necessary for the child, a Regional Health Unit nurse employed by DCS will be contacted to provide consent for the child until the child is further evaluated.[238] If, based upon that evaluation the DCS determines that treatment is necessary to protect the child from harm and is in the child's best interest, DCS will collaborate with the prescribing physician and its own attorney to determine whether to seek judicial intervention.[239]

Connecticut's Department of Children and Families (DCF) established a "DCF Psychotropic Medication Advisory Committee" to create "Guidelines for Psychotropic Medication Use by Children and Adolescents" ("Guidelines"),[240] updated as recently as January 2010.[241] The DCF offices are divided into three Medical Regions,[242] with each region assigned a board-certified child and adolescent psychiatrist as Regional Medical Director.[243] Additionally, DCF has established a Centralized Medication Consent Unit (CMCU), which consists of Psychiatric Mental Health nurses.[244] The CMCU "receive[s] all medication requests and make[s] decisions or triage[s] to the appropriate Regional Medical Director."[245] The CMCU provides consent on behalf of children in care after medication forms have been provided that establish a "clear 'picture' of the child's current condition."[246] The Guidelines are intended to be used by medical and mental health practitioners who serve children and families involved with DCF.[247] The DCF authorizes consent based on recommendations made by its in-house nurses and physicians. As noted in the Guidelines, this process moves away from one where consent to medication is granted by Social Work Program Supervisors, to a process that allows providers to interact directly with medical and nursing staff who are trained and board certified in psychiatric and behavioral health care.[248] The Guidelines do not mention inclusion, or attempts at inclusion, of natural parents.

While each of the foregoing processes offer notable provisions for obtaining consent and attempting to ensure appropriateness of the medications, each offers

236. Bellonci & Henwood, *supra* note 87, at 38.

237. *Id.* at 39.

238. The authority for agency consent came from a lawsuit regarding the use of psychotropic medications on children in care, and a subsequent consent decree mandating the foregoing procedures. Lea Testimony, *supra* note 66, at 20.

239. *Id; see also* TENN. DEPT. OF CHILDREN'S SERVS., ADMINISTRATIVE POLICIES AND PROCEDURES: 20.24(K) (2010), *available at* http://www.tn.gov/youth/dcsguide/policies/chap20/20.24.pdf (detailing procedures for refusal of treatment).

240. CONNECTICUT GUIDELINES, *supra* note 98.

241. *Id.* at 1.

242. *Id.* at 11.

243. *Id.*

244. *Id.*

245. *Id.*

246. *Id.* at 12.

247. *Id.* at 4.

248. *Id.* at 11.

opportunity for additional safeguards. Despite being expansive in the obligations it imposes on child welfare workers and medical providers, Florida's consent process is not flawless: a 2006 internal study by DCFS found that, despite the foregoing safeguards, approximately one in six children receiving psychotropic medications received their prescriptions without the legally required consent.[249] While Connecticut's reliance on medical professionals regarding the appropriateness of recommended medications is prudent and demonstrates responsiveness to the actual needs of children in care, their lack of specific procedures for inclusion of natural parents in their consent process is problematic for the reasons identified in Part III.C *supra.* And, while Tennessee's employment of health care professionals on staff with child welfare agencies again demonstrates a recognition of the needs of children in the system, there exists a risk that complacency, numbing to the concerns psychotropics raise, and other factors, such as concerns about preservation of placements, will impact the impartiality of those professionals.

Given the complex needs of children in care, the need for a well-defined consent process, and the reality of already clogged juvenile court dockets, states should consider establishing Psychotropic Review Boards (PRBs) as a neutral option. PRBs could operate similar to how Citizen Foster Care Review Boards (CFCRBs) operate now. CFCRBs, created by CAPTA, are made up of community volunteers and serve to review an agency's efforts towards permanency and the appropriateness of a given placement for a child.[250] PRBs similarly could be charged with assessing the appropriateness and safety of prescribed medications, as well as assessing the agency's efforts towards obtaining other therapeutic interventions by volunteer physicians or psychiatrists. PRBs would be charged with looking holistically at the mental health needs of a particular child, identifying treatment options and treatment recommendations, and issuing reports to the court and the parties on the existing mental health care provided, including psychotropics prescribed, to a child in care.

Another option for increasing neutrality and legitimacy of recommended treatment, including prescriptions for psychotropic medications, is for child welfare agencies to collaborate with independent partners such as local universities on the appropriateness of the prescribed treatment. Illinois's Department of Children and Family Services utilizes this approach by contracting 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."[251] While the role of the natural parent and judicial oversight in this collaborative process is unclear, it offers to caseworkers needed expert input on the appropriateness of a child's diagnosis, treatment recommendations, and medication regimen.[252] Said differently, this type of collaboration puts into the hands of trained, qualified mental health

249. FLA. DEPT. OF CHILDREN & FAMILIES, A REPORT TO THE SECRETARY: ANALYSIS OF FLORIDA SAFE FAMILIES NETWORK (FSFN) DATA ON PSYCHOTROPIC MEDICATION (2009), *available at* http://www.dcf.state.fl.us/initiatives/GMWorkgroup/docs/PsychMedicationExecSummary.pdf.

250. *See* 42 U.S.C. § 5106a(c) (2006) (establishing citizen review panels to evaluate agencies in their child protection responsibilities).

251. Naylor et al., *supra* note 84, at 182.

252. *Id.*

professionals treatment recommendations that child welfare agencies are ill-equipped, and may have improper incentives, to make.

B. Data Collection

In order to meaningfully regulate psychotropic medications, states must have a clear understanding of their own prescription patterns. Tracking the numbers of children taking one or more psychotropic drugs is one way to obtain that understanding. Despite this, data tracking by states on the numbers of children in their care taking psychotropic medications is markedly absent. Without such tracking, advocates, legislatures, and courts are without needed information to hold child welfare agencies accountable. More importantly, lack of information allows the use of psychotropic medications to continue unchecked, thereby placing children at risk of harm and limiting safeguards necessary to avoid overprescribing.

Data tracking allows states an opportunity to assess prescription patterns and flag particularly concerning or concomitant prescriptions. Tennessee uses data tracking in this way.[253] When a child in foster care in Tennessee is prescribed a psychotropic medication, that prescription is added into the state's child welfare database.[254] As prescriptions are added, the system can send an email alert to the agency's chief medical officer if a particular child has been prescribed: more than one psychotropic medication from the same class; more than three medications in general; any of thirty "concerning" medications; a dosage above the recommended amount; or a medication at an age below the minimum recommended for the drug.[255] This type of data-tracking system offers enhanced accountability for the manner and extent to which children are prescribed psychotropic medications, and allows for additional monitoring of the safety and interplay of the medications.

C. Redefining Foster Provider Roles

A foster placement can be the difference between mental health success and mental health deterioration for a child. States simply must ensure that foster providers are able to attend to the needs of the children for whom they are caring and to find ways to integrate mental health care into all aspects of the child welfare system, including the homes or facilities in which a child is placed. While many foster providers are capable of attending to the complex needs of children placed in their care, many do not have the tools necessary to do so. Indeed, despite the fact that approximately a quarter of all children in foster care homes are placed with relatives,[256] many states waive the certification requirements for kinship care providers in whole or in part,[257] leaving a large pool of care providers without any basic or specialized

253. *Tennessee Begins Tracking Medications for Children in State Custody*, CHILD. VOICE, Nov.–Dec. 2008, *available at* http://www.cwla.org/voice/0811national.htm.

254. *Id.*

255. *Id.*

256. In 2006, approximately one-quarter of all placements were with relative care providers. FOSTER CARE STATISTICS, *supra* note 71, at 1.

257. Amy Jantz et al., *The Continuing Evolution of State Kinship Care Policies*, ASSESSING THE NEW FEDERALISM, 10–13 (Dec. 2002), http://www.urban.org/UploadedPDF/310597_state_kinship_care.pdf

training to assist in managing the mental health needs of children placed in their care.[258] While limited certification may open up pools of providers who otherwise may not be available as a foster placement due either to limited time to engage in the certification classes or likely failure of an otherwise required background check, a "blanket exemption from standards for foster family homes for all relative caregivers" can harm children.[259]

Reinforcing training and stable caregiving by increasing reimbursement funding to care providers is one option to balance the needs of children in care, and to provide incentives for foster provider trainings. The increased funding could be provided regardless of the needs of a particular child in a particular foster home.[260] This type of reimbursement structure has been utilized by Philadelphia's Department of Human Services:[261]

> The only thing that changes when a child become [sic] eligible for treatment foster care is the rate that the foster care agency is paid to support more intensive services. The foster parents continue to get an enhanced rate because of their training regardless of the current status of the child living in their home.[262]

Moving toward a universal foster care reimbursement system that is focused on training and results, would "place[] a far greater premium on the training and special skills of those adults serving as the foster parents than does the current reimbursement structure"[263] without the requirement that a child carry a particular diagnosis for that increased rate. More foster providers may come forward, and kinship care providers would have more incentive to receive training. Paying care providers based on their level of training and for demonstrating skill in positive parenting and stability has been shown to be effective: "[S]tudies of treatment effectiveness showed that youths in therapeutic foster care made significant improvements in adjustment, self-esteem, sense of identity, and aggressive behavior."[264] Those gains were sustained according to a follow-up study conducted two years after leaving the therapeutic foster home.[265] Given what is understood about the mental health needs of children in foster care, a universal training model that allows all children the benefit of providers who have been trained to attend to their evident, and underlying, mental health needs would assist in

(identifying fifteen states with exact same certification standards for kinship and non-kinship care providers, and twenty-three states that generally apply same certification standards to kinship and non-kinship care providers but allow for waivers of certain certification requirements for those who are kinship care providers).

258. *See, e.g.*, Henry Complaint, *supra* note 91, at 41–42 (identifying numerous children placed in homes of uncertified kinship care providers, including at least one child who was abused and neglected while in home of her aunt).

259. *Id.* at 67–68.

260. Child-specific expenses—such as non-psychotropic medications, nebulizers, or other out-of-pocket costs to the care provider—should be reimbursed.

261. Lyons & Rogers, *supra* note 124, at 971.

262. *Id.*

263. Weithorn, *supra* note 119, at 1500.

264. *Id.* at 1499 (quoting U.S. DEP'T OF HEALTH AND HUMAN SERVS., REPORT OF THE SURGEON GENERAL'S CONFERENCE ON CHILDREN'S MENTAL HEALTH: A NATIONAL ACTION AGENDA 177 (2000)) (internal quotation mark omitted).

265. *Id.*

reducing placement changes, increasing stability, and more in-home behavioral interventions, likely reducing the need for, and use of, psychotropic medications.

D. The Caseworker's Role

While caseworkers do not possess the expertise needed to determine when or whether a psychotropic medication is clinically appropriate, or when or whether it can be safely stopped, they do have obligations to ensure that the care provided to the children on their caseload is medically appropriate. Caseworkers must be trained on the risks of psychotropic medication, and the standards of care endorsed by the American Academy of Child and Adolescent Psychiatry,[266] the Child Welfare League of America,[267] and the American Academy of Pediatrics,[268] and the legal rights of parents. Trainings should be offered that direct workers and supervisors away from a rule-driven approach to mental health treatment, including psychotropic medication use, to one that encourages questions and requires understanding of the need for any given medication. Caseworkers must be encouraged to demand alternatives or concurrent therapies in conjunction with psychotropic medication, and should be encouraged to seek second opinions, where appropriate.[269] Complacency by caseworkers in the face of this epidemic is simply not an option.

E. Change Beyond Child Welfare Agencies

Although beyond the scope of this Article, it is worth noting the significant role psychiatrists and physicians have in curbing this epidemic. Physicians and psychiatrists must ensure that they are prescribing psychotropic medications to children in foster care in accordance with the current standard of care. There must be open dialogue among the physicians and psychiatrists prescribing psychotropics, including information on side effects and other risks associated with psychotropic medications, and routine trainings on best practices for children in foster care. Prescribing physicians and psychiatrists who treat children in foster care must inform themselves of the agency's consent process and insist on dialogue with the caseworkers, care providers, children, and, where appropriate, parents, to ensure that all interested parties are as

266. *Psychiatric Medications for Children and Adolescents*, *supra* note 133, at 1 ("Psychiatric medication should be used as part of a comprehensive plan of treatment, with ongoing *medical assessment* and, in most cases, *individual and/or family* psychotherapy."); *see also* AACAP BEST PRINCIPLES, *supra* note 51 (identifying "basic principles" and "best principles"—divided into minimal, recommended, and ideal standards—"regarding psychiatric and pharmacologic treatment of children in state custody").

267. CHILD WELFARE LEAGUE OF AM., CWLA STANDARDS OF EXCELLENCE FOR HEALTH CARE SERVICES FOR CHILDREN IN OUT-OF-HOME CARE 18 (Julie Gwin ed., rev. ed. 2007) (stating that "psychotropic medication should not be used as the sole treatment for children with mental health disorders" and "will be the subject of ongoing examination").

268. Press Release, Am. Acad. of Pediatrics, Foster Children Need Better Coordinated Health Care to Ensure Appropriate Use of Psychotropic Medications (May 8, 2008) (on file with author) (listing recommendations to protect children including: providing medical home for foster children; establishing protocol to be followed when prescribing psychotropic medications to foster children; creating system to ensure effective transfer of physical, developmental and mental health information among professionals who treat foster children; and creating system to track use of psychotropic medications among foster children).

269. Bellonci & Henwood, *supra* note 87, at 13, 26.

informed as possible about the child's current needs. Where information is lacking, treating physicians should stress and encourage follow-up appointments for monitoring the prescribed medications. In short, they must understand this epidemic and evaluate their own prescription practices in response.

VI. CONCLUSION

Children in foster care have broad, often significant, mental health needs. Resources for attending to those needs are scarce and collaboration between the child welfare and mental health systems is limited, at best. Both despite, and in response to, these realities, states are prescribing psychotropic medications to children in their care at epidemic rates. The result is thousands of children in foster care being placed at risk of potentially significant side effects, and a high likelihood that these children are not receiving the long-term mental health treatment they need and deserve.

To date, most states have ignored this epidemic. It can be ignored no longer. States must take swift action; they must engage in meaningful collaboration with mental health professionals and open dialogue with doctors who prescribe psychotropic medications; review and modify internal practices that promote and encourage the use of psychotropic medications; develop legally sufficient consent processes and increase accountability by tracking prescriptions; and build a roadmap of actionable steps to regulate how psychotropic medications can be prescribed to children in their legal custody in response to the Fostering Connections Act. This Article has offered tools for states to begin this process. Meaningful regulation of psychotropic medications by children in foster care is not an option. Children trusted to the care of our states are owed more than complacency.