Dear Practitioner,

This letter is to inform you how our State is working to improve our common goal of safe and appropriate psychotropic medication treatment of youth in foster care. These efforts are in response to federal initiatives to improve care of these vulnerable youth. A recent Government Accountability Office (GAO) report identified specific concerns about high dosing, polypharmacy, treatment of young children (including psychotropic medication treatment of youth <1 year old), and inadequate oversight. The GAO recommended that medication monitoring programs follow American Academy of Child and Adolescent Psychiatry (AACAP) best practice guidelines for consent, consultation, information, and oversight. In 2011, The Child and Family Improvement of Services and Innovations Act was enacted (PL 112-34), which requires each State to

"Plan for oversight and coordination of health care services for any child in foster care to include an outline of:

- **The monitoring and treatment of emotional trauma associated with a child's maltreatment and removal from home.**
- **Protocols for the appropriate use and monitoring of psychotropic medications".**

In Maryland, we are fortunate to have a strong network of community providers and dedicated case workers who support the mental health needs of youth in foster care. The attached document provides information to practitioners on the following:

- Programs to improve monitoring of psychotropic medication treatment.
- Maryland guidelines for psychotropic medication treatment of youth in foster care.
- Resources for providers for consultation and information on safety monitoring.
- Information on screening and treatment of trauma related mental health disorders.

The psychotropic medication guidelines were developed with strong input from consumers/family advocates, state agency leadership, child psychiatry and pediatric experts, and providers. They will be reviewed twice a year and revised to incorporate evolving information on evidence-based treatment and best practices for youth in foster care. This information is not intended to dictate standards of care in your practice, but rather to improve consistent and safe care for foster care youth, who often have complex mental health needs.

We thank you for your commitment, dedication, and service in caring for youth who are in the care and custody of the local Department of Social Services in Maryland. If you have any feedback on this document or have any questions, please feel free to contact Ms. Jacqueline C. Powell, Education/Health Policy Analyst at jpowell@maryland.gov.

Respectfully,

Theodore Dallas, Secretary
Maryland Department of Human Resources

Joshua M Sharfstein, Secretary
Maryland Department of Health and Mental Hygiene

BACKGROUND INFORMATION

Unique challenges of psychotropic treatment of youth in foster care:

- Up to 100% of youth may have experienced significant trauma
- Provider may not have access to early development or prior treatment history
- Medication consent may be provided by someone besides the parent
- Youth may experience disruptions in placement that lead to changes in treatment team

National data on psychotropic treatment of youth in foster care and Medicaid insured youth:

- Nearly 18% of youth in foster care receive a psychotropic medication compared with 6.2% of non-foster care Medicaid insured youth and 4.8% of private insured youth
- There was an estimated 62% increase in antipsychotic medication prescribing to Medicaid insured youth from 2002 – 2007
- Approximately 1/7 of antipsychotic medications prescribed to Medicaid insured youth had a diagnosis of ADHD-only
- 11% of Medicaid insured youth ages 3-5 years old prescribed antipsychotic medication had no psychiatric diagnosis

Predictors that a child in foster care will be prescribed a psychotropic medication:

Age: Children in foster care are more likely to be prescribed psychotropic medications as they grow older. The likelihood of receiving multiple psychotropic medications also increases with age.

Gender: Males in foster care are more likely to be receiving psychotropic medications (19.6 percent) than their female counterparts (7.7 percent).

Behavioral Concerns: Children with behavioral problems, including internalizing and externalizing issues, are much more likely to be prescribed psychotropic drugs.

Placement Type: The likelihood that a child will be taking any psychotropic medication tends to increase as placements become more restrictive. Eleven percent of children residing in in-home settings receive psychotropic medications versus nearly 14 percent in foster care homes. In group or residential homes, where the behavioral and mental health needs of children are most severe, nearly half of the young people are taking at least one psychotropic drug. Additionally, children in more restrictive placement types are more likely to be taking multiple psychotropic medications.

There are also significant geographic variations within and across States in the prevalence of psychotropic use among children in foster care, suggesting that factors other than clinical need may be influencing prescribing practices.

Maryland State Agencies that Oversee Psychotropic Treatment of Youth in Foster Care

In Maryland, the authorization, oversight, and financing of psychotropic medications for children in foster care is directed through collaborative work by two state agencies. The Maryland Department of Human Resources (DHR) is the State's Child Welfare Agency. As such, DHR is responsible for the consent and monitoring of psychotropic medication treatment of youth in foster care. The Maryland Department of Health and Mental Hygiene (DHMH) as the State's public health department is responsible for the health status of Maryland residents and ensuring access to quality health care. Within the Department, two major administrations have responsibility for overseeing and financing psychotropic medications:

- Office of Health Care Financing- oversees Medicaid and the financing of psychotropic medications for all individuals enrolled in Medicaid, including children in foster care.
- The Mental Hygiene Administration (MHA) is the State agency responsible for oversight and provision of mental health services to all individuals enrolled in Medicaid, including children in foster care.

MARYLAND'S MEDICATION MONITORING AND OVERSIGHT PROGRAMS

The Psychopharmacology Monitoring Database

The Psychopharmacology Monitoring Database is an initiative by State leadership at MHA and Child Welfare. The database links administrative records from MHA (i.e. mental health claims) with child welfare data on youth in out-of-home placement. This initiative has been ongoing for the past three years as a result of successful collaboration among the State child serving agencies and faculty at University of Maryland, Schools of Pharmacy and Medicine. The data linkage has been approved for statewide evaluation. There are recent efforts to work with jurisdictions to create linkages that would facilitate better monitoring at the direct patient care level. The evaluations that have been completed to date include: a) time trends in psychotropic use; b) antipsychotic persistence among very young children; c) use of concomitant antipsychotic treatment and the impact on hospitalization and emergency department use; and d) use of antipsychotic medication among children with attention-deficit/hyperactivity disorder (ADHD) with and without comorbidities. Evaluations currently in progress are: a) assessment of antipsychotic dosing in relation to hospitalization; and b) initiation of antipsychotic use and association with placement instability. This work has been presented at the 2013 Systems of Care Training Institute (SOCTI) and reports are periodically shared with the state administration.

Peer to Peer Program

The Peer Review Program for Mental Health Medications (also known as the Peer to Peer Program) operates through the Maryland Medicaid Pharmacy Program. This program, which was implemented in October 2011, conducts pre-authorization review for antipsychotic treatment for youth. As of September 2013, the program covers youth 10 years old and younger. By January 2014, the program will cover youth 17 years old and younger. This program impacts all Medicaid enrolled youth, which included all children in foster care. Providers are required to submit indication for medication treatment/target symptoms, baseline side effect assessment (e.g. fasting blood work is required), information on referral for non-medication psychosocial treatments (e.g. psychotherapy), the antipsychotic medication and dose being requested, and a list of any co-prescribed medication. Initial review is completed by a pharmacist, and a child psychiatrist consultation is provided if the required criteria are not met and the prescriber wishes to appeal the disapproval. Ongoing review of antipsychotic treatment is required every six months to assess if adequate safety monitoring and treatment response has been achieved to support ongoing medication treatment. In the case that a child is deemed to be at a higher risk for side effects or where the drug regimen is unusual or complicated, ongoing review may take place more frequently.

Consultation Programs

Maryland Behavioral Health Integration in Pediatric Primary Care (B-HIPP)

Maryland Behavioral Health Integration in Pediatric Primary Care (B-HIPP) is a free state-wide consultation, continuing education, and resource/referral program for pediatric primary care providers (PCPs) funded by the Maryland Department of Health and Mental Hygiene and the Maryland State Department of Education. B-HIPP supports the efforts of pediatric primary care

providers in the assessment and management of mental health concerns among their patients through a consultation phone line. PCPs are able to have questions answered about diagnosis, medication, and other mental and behavioral health concerns answered by experts including child psychiatrists. B-HIPP is able to provide consultation to PCP's regarding children from infancy to transitional age youth, and their families. B-HIPP also seeks to increase access to children's mental health services by improving linkages between primary care providers and the mental health providers in their communities, rather than by creating new services. The clinical work for this project is carried out as collaboration among the University of Maryland School of Medicine/Department of Psychiatry, the Johns Hopkins University School of Public Health, and the Salisbury University School of Social Work.

B-HIPP is available Monday through Friday from 9:00 AM to 5:00 PM by calling 1-855-MD-BHIPP.

Making All Children Healthy (MATCH) Program

Making All Children Healthy (MATCH) program is a Baltimore City initiative that was developed and implemented by the Baltimore City Department of Social Services (BCDSS) in collaboration with Health Care Access Maryland. MATCH oversees the health care of 3776 children in foster care, which is 52% of youth in foster care statewide. MATCH provides medical case management and health care coordination for children and youth in foster care. In addition to coordinating medical and dental care, the program assures the completion of a mental health assessment of youth upon entry to foster care and completes referrals and follows mental health treatment. The program incorporates a child psychiatrist consultant in their review of cases with complex psychiatric health needs. The MATCH program is currently exploring options to develop direct child psychiatrist consultation to prescribers and to develop a process for psychotropic medication consent that utilizes clinical review by MATCH staff. The program plans to share information regarding our psychiatric case reviews with the Peer to Peer Program to decrease duplication of case reviews. Prescribers should expect to hear more details from the MATCH program within the next year.

GUIDELINES FOR ASSESSMENT, CONSENT/ASSENT, TREATMENT, AND MONITORING

Assessment Guidelines

Guideline 1) A Psychiatric Evaluation should be completed prior to prescribing psychotropic medications. The baseline assessment of a child or adolescent prior to initiating psychopharmacological is complex.

Guideline 2) A Medical History should be obtained and Medical Evaluation completed prior to the prescription of a psychotropic medication.

Guideline 3) There should be communication with other professionals involved with the child to obtain collateral history in efforts to monitor outcomes and possible side effects during medication trial.

Treatment and Monitoring Guidelines

Guideline 1) The psychosocial and psychopharmacological treatment plans should be based on the "best available evidence" for treatment and safety monitoring.

Guideline 2) A plan that monitors the youth's short and long term progress should be developed.

Guideline 3) Whenever possible, medication regimen changes should involve systematic changes to only one medication at a time.

Assent and Consent for Treatment Guidelines

Guideline 1) Feedback should be provided to the youth, parent, foster parent and case worker regarding the youth's diagnosis/disorder, treatment and monitoring plan.

Guideline 2) Documentation of a Youth's Assent and an Informed Consent of the parent, legal guardian or local department of social services must be completed prior to prescribing psychotropic medication.

Guideline 3) There is a need for a discussion that focuses on the risk and benefits of proposed and alternative treatments.

Implementation of Treatment Guidelines

Guideline 1) Medication trails should be implemented using an adequate dose and for an adequate duration of treatment.

Guideline 2) Reassessment of the youth if youth does not respond to the initial medication trail as expected.

Guideline 3) A clear rationale for the use of medication combinations is needed.

Discontinuing of Psychotropic Medications

Guideline 1) The identified time to discontinue psychotropic medication should be planned so that there is minimal risk for an unmonitored relapse/recurrence of symptoms.

Criteria Warranting for a further Review of a Youth's Clinical Status

The following situations warrant further review of a patient's case. These criterions do not necessarily indicate that psychotropic medication treatment is inappropriate, but they do indicate a need for further review. For youth and children that are being prescribed a psychotropic medication, any of the following prompts a need for additional review of the child's/youth's clinical status:

Information Reviewed	Clinical Flag for Further Review
Child age	Antidepressant medication for a child <4 years old Antipsychotic medication for a child <4 years old Stimulant medication for a child <3 years old
Provider specialty	Primary Care Provider without specialized mental health training or psychiatry consultation treating a mental illness other than ADHD, or uncomplicated depression or anxiety
Evaluation	Absence of a thorough evaluation and DSM-V diagnosis
Indication	Medication prescribed is not consistent with national practice guidelines and/or expert consensus criteria (e.g. refer to Medicaid Peer Review Program)
Polypharmacy	Treatment with > 4 psychiatric medications (except side effect medication)
Multiple medications from the same class	Treatment with >1 antipsychotic medication; >1 antidepressant medication; and/or >1 mood stabilizer
ECG, lab data, BMI%	Youth who are obese or underweight; abnormal ECG; abnormal laboratory results

Foster Care Case Worker's Role in Monitoring Psychotropic Medications

As set forth in Social Services Administration Policy Directive SSA-CW# 14-12 Oversight and Monitoring of Psychotropic Medications, it is the role of the foster care case worker to regularly review medication compliance and the medication's effect on the youth during the monthly home visits. At each home visit with a youth prescribed psychotropic medications, the following items must be discussed with both the caregiver and the youth:

Caregiver discussion must include:

- Information about the intended effects and any side effects of the medication.
- Compliance with all medical appointments, including dates of last and upcoming appointments with the prescribing clinician.
- Medication availability, administration and refill process.

Youth discussion must include (using developmentally appropriate language):

- Possible side effects and benefits of the medication.
- The administration of medication; time frame and regularity.

It is also important for the worker to review with the youth and caregiver the following points for "SAFE" care:

- **S**ide effects from medication should be reported to both the foster care case worker and the prescribing clinician.
- **A**ppointments for medication monitoring and lab work (if applicable) should be kept on a routine basis.
- **F**amilies and youth should be supported to address their questions and concerns about medication during appointments with the prescriber.
- **E**nding medication abruptly can sometimes cause physical health problems. Families and youth should discuss plans to discontinue a medication with their prescriber *before* stopping the medication so that any medication changes are done safely.

ADDITIONAL INFORMATION

Child Welfare Training Academy: Annual training program offered to foster care case workers on 1) principles of evidence based and safe psychotropic prescribing; 2) importance of universal trauma screening in care of youth in foster care; and 3) information on how to identify evidenced based psychosocial treatments for youth in foster care.

Evidence Based Trauma Screening and Treatment Information: The following information is reviewed as part of the training

For youth 8 years and older:

- Child Stress Disorders Checklist- Short From (CSDC-SF) Saxe, G. N., Enlow, M.B. (2010)
- Abbreviated UCLA PTSD Reaction Index for the Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition). Pynoos, R.S., Steinberg, A.M. (2001)

For youth under the age of 8:

- Young Child PTSD Screen (YCPS). Scheeringa, M. (2010)
- Modified Abbreviated UCLA PTSD Reaction Index for the Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition). Pynoos, R.S., Steinberg, A.M. (2001)

For any member of the family:

- Adverse Childhood Experience Questionnaire (ACE). Robert F. Anda, R. F., Felitti, V.J. (1998)

RESOURCES

Trauma informed resources:

National Child Traumatic Stress Network: www.nctsn.org

Trauma informed and child welfare informed resources:

California Child Welfare Clearinghouse: www.cachildwelfareclearinghouse.org
Chadwick Trauma-Informed Systems Project:: www.ctisp.org
Chadwick Center: http://www.chadwickcenter.org/
American Professional Society on the Abuse of Children:
http://www.apsac.org/practice-guidelines

Trauma informed treatment resources:

American Academy of Child & Adolescent Psychiatry: www.jaacap.org
Trauma Focused Cognitive Behavior Therapy: www.musc.edu/tfcbt
Family Informed Trauma Treatment: http://fittcenter.umaryland.edu
SAMHSA National Registry of Evidence-based Programs and Practices:
http://www.nrepp.samhsa.gov/