



CalSWEC

Literature Review: Psychotropic Medication and Children and Youth in Foster Care

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Abstract

This review identifies oversight and monitoring policies, protocols, and guidelines that child welfare social workers should consider when coordinating the delivery of services for children and adolescents in foster care who are prescribed psychotropic medications. Using a framework that relies on teaming and advocacy with a trauma-informed lens, this review identifies a process and tools social workers can use to best meet the needs of children and youth.

Social workers play a leading role in ensuring short- and long-term safety and wellbeing goals are met when caring for foster children and youth in need of mental health care services. Psychotropic medication use is particularly concerning for children and youth in foster care who are disproportionately prescribed such drugs (de Sá, (2014); Sheldon, Berwick, & Hyde, 2011; U.S. Government Accountability Office [GAO], 2011). It is therefore important for social workers to recognize the short- and long-term risks associated with psychotropic medication use and the lack of research on their effectiveness and safety (Hughes & Cohen 2010). Despite these concerns, social workers need to also recognize that proper psychotropic medication use can help alleviate suffering in children and youth who are battling psychiatric conditions (National Survey of Child and Adolescent Well-Being, 2012) and must take the necessary steps to find resources that will help alleviate this suffering accordingly.

Further, the social worker must be able to work across systems of care and be informed about legal and professional obligations throughout the different stages and processes in the psychotropic medication oversight and monitoring system highlighted in this document:

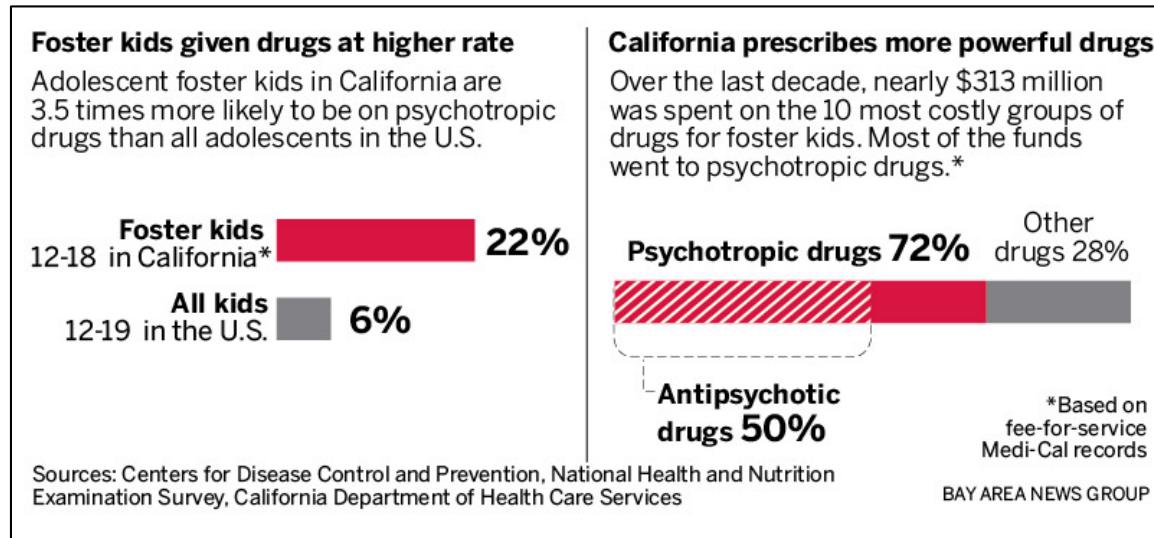
[Assessment and Evaluation](#), [Consent and Authorization Process](#), [Psychosocial and Medication Treatment Plan](#), [Monitoring](#), and [Psychotropic Medication Discontinuation Plan](#).

Background

Per Welfare & Institutions Code, Section 369.5(d), “psychotropic drugs are those medications prescribed to affect the central nervous system to treat psychiatric disorders or illnesses.”

Psychotropic medications alter feelings, cognition, and behavior. Stimulants, for example, can change behavior within one hour in 60–70% of the children who take them (Cohen & Sengelman, 2008). According to Breggin (2000), parents, clinicians, and others involved in the care of the child or youth can mistake some stimulant effects as therapeutic. Child and youth advocates fear that often psychotropic medications are used to chemically restrain children or youth to benefit caregivers without considering the full impact the drugs will have on the child’s or youth’s developing brain (de Sá, 2014; Longhofer, Floersch, & Okpych, 2011).

The use of psychotropic medication among children and youth in the United States has increased significantly over the last two decades, particularly for children and youth in foster care (Longhofer, Floersch, & Okpych, 2011; Raghavan, Lama, Kohl, & Hamilton, 2010). Raghavan, et al., 2005 estimate 13% of all children and youth in the child welfare system nationwide receive medications compared to 4% of children and youth in the general population. In 2014 the *San Jose Mercury News* found that from 2004 to 2014, nearly 1 out of 4 adolescents in the California foster care system received psychotropic medications—3.5 times the rate for all adolescents nationwide. Of children and youth who were prescribed psychotropic medications, 60% received the strongest class—antipsychotics. What is particularly concerning is the prescription of multiple medications (i.e., polypharmacy). The newspaper study also found that in 2013, 12.2% of foster care children and youth who were prescribed medications were prescribed more than one medication at a time.



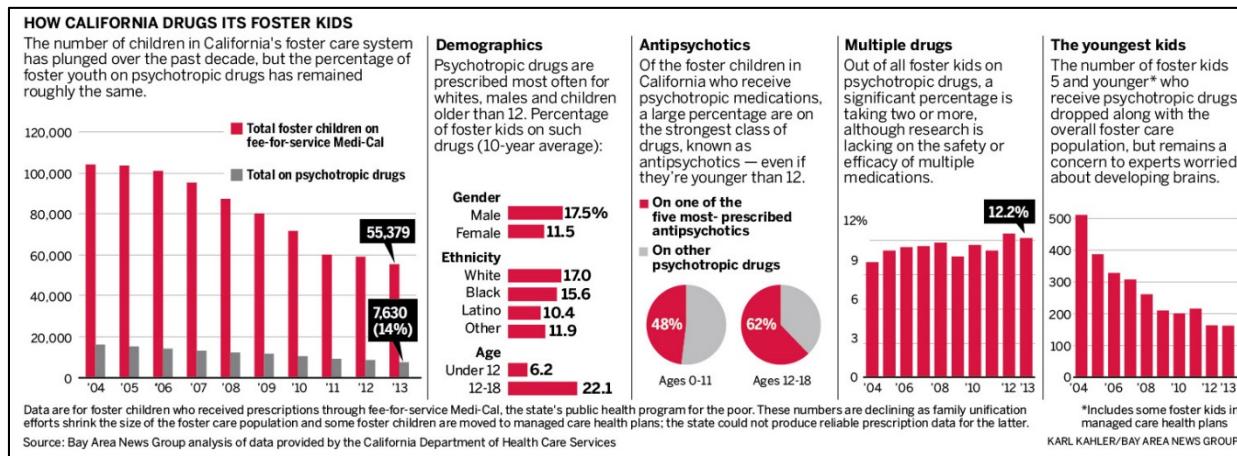
Mackie et al. (2011) list a number of factors, which may or may not be related with clinical need, that explain why this population of children and youth are disproportionately prescribed psychotropic medications, including: higher rates of trauma victimization and mental health disorders found in this population; trauma caused by being removed from family of origin and multiple placement changes thereafter; and the complex emotional and behavioral symptoms that accompany all these underlying circumstances; lack of clear oversight and monitoring guidelines and protocols; an increase in medication prescription in outpatient settings; and inadequate access to Medicaid services.

High-Risk Factors and Circumstances

Research repeatedly finds that children and youth in the foster care system are diagnosed with mental health disorders more often than children not in foster care and are therefore more likely to be prescribed psychotropic medications (Longhofer, Floersch, & Okpych, 2011; [Sheldon, Berwick, & Hyde, 2011](#)). The most common diagnoses among children and youth in foster care are conduct disorder/oppositional defiant disorder, depression, attention deficit/hyperactivity disorder, and posttraumatic stress disorder. Commonly prescribed medications for children and youth in foster care include antipsychotics to treat schizophrenia, bipolar disorder, and autism with irritability; stimulants to treat symptoms of attention deficit hyperactivity disorder; antidepressants to treat major depression and obsessive compulsive disorder; and mood stabilizers for aggressive behavior and unspecified emotional problems.

Major studies and government agencies recognize several demographic factors, child youth characteristics, and other circumstances that increase a child's likelihood of being prescribed psychotropic medications ([Sheldon, Berwick, & Hyde, 2011](#); [Drugging Our Kids, 2015](#); [Information Memorandum: Oversight of Psychotropic Medication for Children in Foster Care, 2012](#); Raghavan, et al., 2010).

- **Age and Gender:** Nationwide and individual state research indicate that as foster care children grow into adulthood, they are more likely to be prescribed psychotropic medication and are more likely to receive more than one psychotropic medication at a time. Research conducted by the *San Jose Mercury News* showed that 6.2% of children in the California foster care system under age 12 received psychotropic medications compared to 22.1% of 12–18-year-olds. In the same study, 17.5% of males were prescribed psychotropic medications compared to 11.5% of females ([Drugging Our Kids, 2015](#)).



- **Behavioral Concerns:** Children characterized with having social-emotional behavioral dysregulations are most often prescribed psychotropic medications.
- **Placement Type:** Children and youth residing in group homes are especially characterized with having a significant level of complex emotional and behavioral dysregulations that are difficult to manage and may put them and others in physical and emotional danger. As a result of these behavioral characteristics combined with residential group dynamics, children and youth in group homes are more likely to receive psychotropic medications and polypharmacy prescriptions. In California, as reported by the *San Jose Mercury News*, more than half of the foster children residing in group homes have a psychotropic medication court authorization in their file (up to 100% of in some counties that have fewer children residing in group homes).
- **Geographical areas:** Researchers find that other than clinical need, variations in policies/guidelines in assessment, evaluation, and oversight of psychotropic medication use (along with other characteristics in the mental health system) within and across states may influence over- or under-prescription practices and use of these medications (Leslie, Raghavan, Hurley, Zhang, & Aarons, 2011; Mackie et al., 2011; Raghavan, Lama, Kohl, & Hamilton, 2010). Rural areas, with less access to mental health care providers, for example, may not provide adequate medication treatment for children and youth suffering from mental illnesses (Information Memorandum: Oversight of Psychotropic Medication for Children and youth in Foster Care, 2012).

Other Factors

Other factors include situations that disrupt the child's homeostasis, such as shifting placements, transitions in caregivers and state workers, breaches in continuity of care, and uncoordinated mental health care among the child's professional and personal network (Mackie et al., 2011).

Further, professional literature and government documents identify several red flags that may signal improper prescription and use of psychotropic medications (Bullard, Davis, Moore, & Morris, 2013):

- **Too many:** Multiple medication treatment with two, three, or more medications at the same time to treat comorbid conditions in children and youth is particularly concerning because research of its safety and efficacy is extremely limited.
- **High dosages:** Adult-level doses in child-sized bodies produce high concentrations of medication in the child's blood that can cause serious physical and mental harm to the child.
- **Too soon:** The child receiving a medication prescription within a few weeks of placement is concerning because the child might be displaying symptoms stemming from difficulty adjusting to a new place, not from a mental illness.
- **Too young:** Safety and drug efficacy data for younger children and youth do not exist for most drugs, especially for polypharmacy treatment.
- **Too long:** Many psychotropic medications carry cumulative risk. The longer the exposure, the greater the risk of morbid weight gain, diabetes, tardive dyskinesia, excessive sedation, heart attacks, and other serious adverse effects.
- **Non-tested medications (Off-label use):** Most pediatric uses of psychotropic drugs are "off label," which are drugs the FDA has approved only for relatively uncommon conditions, such as childhood schizophrenia, psychosis, or autism.
- **Treatment of symptoms with medication only:** The child does not receive therapy, counseling, or other therapeutic interventions such as extracurricular activities in conjunction with medication.

Psychotropic Medication Oversight and Monitoring System

The state has taken steps to build upon previous legislation and has expanded and developed new guidelines that continue to promote the basic principles of safety, permanency, and wellbeing, with the added goal of reducing short- and long-term harm caused by inappropriate prescriptions and use of psychotropic medications. As part of the Foster Care Quality Improvement Project, The California Department of Health Care Services (DHCS) and the CDSS released the [California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care, 2015](#). The new guidelines create a shared understanding of oversight and monitoring of psychotropic medication practices for both child welfare services and mental health services.

The guidelines set expectations for physicians, social workers, mature children and youth, parents, caregivers, Tribal members, and all other psychotropic medication stakeholder to

collaborate in strengthening the oversight and monitoring of psychotropic medications ("California guidelines," 2015). [All-County Information Notice No. 1-05-14](#) provides guidelines for sharing required information with caregivers to facilitate their involvement in providing care for their children and youth.

Medication stakeholders or team members in the psychotropic medication oversight and monitoring system include the foster youth or child (who, when appropriate, has the right to request, consent, reject, or agree to medications), parents, placement homes and agencies, caregivers, public health nurses, counselor's schools, therapist, board certified or eligible prescribing physician, judges, attorneys, probation officers, court-appointed special advocates (CASA), and other caring adults the child chooses ([California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care, 2015](#)).

Social Workers Roles and Functions

As intermediators among parents, caregivers, schools, and physicians, social workers play a leading role in ensuring goals and expectations for the child's care are clear to all team members. They perform a variety of functions and tasks including making medication referrals, consulting with prescribers, gathering, recording and processing information for assessment and evaluation, monitoring treatment, assisting with assessing treatment response (Moses & Kirk, 2006).

In addition to serving as a team facilitator social workers have an assessment and advocacy role. Children and youth in foster care have unique needs particular to their experience. They further express their needs in complex ways through often difficult behavior. Social workers regularly deal with such complex situations and therefore must develop a heightened sense of situational awareness to deliver individualized care to meet mental health care needs. The following sections provide different resources with key information and questions social workers need to consider when delivering and coordinating mental health care services.

Assessment and Evaluation

Social workers gather and review psychosocial information before making a medication referral and use this information to assist prescribers with the initial assessment and evaluation. In accordance with Katie A. core practice guidelines, when applicable, the social worker engages and fosters collaboration with the child's mental health professional and personal support network. Key questions and appropriate information transferred between team members will reduce the risk of misdiagnosing a child and create a high-quality assessment to inform the child's diagnosis and determine appropriate course of treatment.

According to the [California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care, 2015](#) the following information needs to be gathered by the social worker, when available, and provided to the prescribing physician, ideally five business days prior to the first appointment (See [ACIN No. 1-05-14](#) for more detail about sharing information with caregivers. Some information must have court or child's attorney approval before sharing. Your county can also provide advice on best practices for sharing information):

1. The Detention Hearing Report describes what happened to the child and why the child was removed from the home. These conditions typically are the 'root cause' of the child or youth's emotional, cognitive, and/or behavioral dysregulation.

2. The Jurisdiction/Disposition Report, or other documentation, includes additional information regarding the abuse and/or neglect experienced by the child in the current referral, history of prior referrals and cases (if applicable) which provides context for the current case and more details regarding why out-of-home care was necessary.
3. Copies of significant additional court reports, i.e., those that document major changes in the family's situation.
4. Copies of all prior psychological evaluations and Initial Treatment Plans/Updates for the child.
5. All prior mental health, physical health, and developmental records.
6. Copies of psychiatrist's Admission and Discharge summaries and the medical H & P (History and Physical) report from all psychiatric hospitalizations for the child.
7. Order Authorizing Health Assessments, Routine Health Care, And Release of Information (Blanket Court Order) or case-specific forms signed by the Court, as per county process).
8. History of Child Placement report.
9. Current Health and Education Passport (HEP).
10. Individualized Education Plan (IEP) and IEP Triennial evaluation (Psychoeducational Assessment Report conducted by school staff once every three years as a condition of initiating and continuing an IEP), if applicable.
11. Medication log to be attached to the psychotropic medication protocol application [JV 220](#), if applicable.

Assessing Caregiver Readiness

It is important for social workers to consider and assess the caregiver's resources and capacity to provide support for the child's mental health needs. Social workers need to consider factors that can contribute to inappropriate use of medication and factors that may impede treatment such as caregiver's lack of understanding of symptoms or common side effects and inadequate supervision of medication adherence (The American Academy of Child and Adolescent Psychiatry [AACAP], 2009). Other assessment sources of information include child's self-report, parent, and teacher reports.

Resource Families (formerly known as foster parents) and other caregivers may become overwhelmed by the needs of children and youth with mental and behavioral health difficulties. As the child's or youth's care plan progresses, social workers need to ensure caregivers receive the psychoeducation they need to support their children.

Consent and Authorization

Informed consent and judicial authorization is required before children and youth under the jurisdiction of the court can begin psychotropic medication treatment and are part of national and state effort to reduce inappropriate use of psychotropic medications and adverse side effects.

Informed Consent

The underlying best practice principle behind informed consent is the importance of providing children, youth, and their parents, guardians, and caregivers with the necessary education that will guide them in making informed medical decisions and carrying out their medical care. Before initiating the treatment, and depending on the child's legal circumstances and developmental stage, the prescribing physician is required to inform the child and legal caregiver of the risks and benefits associated with the recommended treatment plan, alternative treatments, and the option of no treatment as part of the consent and assent process ([California Guidelines, 2015](#)). It is therefore important that social workers assess and ensure children, youth, and caregivers receive the help necessary to make medical decisions about their mental health care.

Social workers have the shared responsibility to help advocate for children and youth and protect their independence and autonomy throughout the consent and assent process, by ensuring mature children and youth are involved in making decisions about their mental health care. In response to concerns about abuse and misuse of psychotropic medications, it is important to keep children and youth physically and mentally safe by hearing, respecting and responding to what they verbalize and communicate, implicitly and explicitly, about their bodies, thoughts, and feelings. Social workers can help do this by ensuring children, youth, and their caregivers understand and can articulate the reasons for treatment and by informing them of their mental health rights as outlined in the [Foster Youth Mental Health Bill of Rights](#).

Further, preparation for medical visits social workers are asked to review with children and youth the list [of Questions to Ask about Medications](#), and help make the right referrals to address any concerns the child may have. The U.S. Department of Health and Human Services also released [Making Healthy Choices: A Guide on Psychotropic Medications for Youth in Foster Care](#). This tool provides youth with practical questions to consider in their mental health care.

Authorization

While local county practice and local rules of court determine the exact tasks in this authorization process, social workers and probation officers have the shared responsibility along with medical and other professional team members to ensure and verify that all legal measures and procedures to protect the child's safety, wellbeing, and rights are followed.

Judicial authorization is required before a child or youth under the jurisdiction of the court is administered psychotropic medications. Authorization is obtained via the Psychotropic Medication Protocol application, JV-220 and all its attachment forms ([Rule of Court Rule 5.640, 2014](#)):

- Information About Psychotropic Medication Forms ([JV-219-Info](#))
- Application Regarding Psychotropic Medication ([form JV-220](#))
- Prescribing Physician's Statement-attachment ([form JV-220\(A\)](#))
- Proof of Notice: application Regarding Psychotropic Medication ([form JV-221](#))
- Opposition to Application Regarding Psychotropic Medication ([form JV-222](#))
- Order Regarding Application for Psychotropic medication ([form JV-223](#))

As outlined in the Rules of [Court Rule 5.460, 2014](#) the prescribing physician initiates the authorization process by completing the Physician's Statement-Attachment form, JV-220 (A) and describing the underlying reasons why the child should receive psychotropic medication treatment. Child welfare agencies and probation departments must request authorization from the

court within three business days of physician's request. The court must approve, deny or set the request for a hearing within seven days. Social workers or probation officers coordinate and ensure official approval or denial is received from court staff ([ACIN No. I-30-15, 2015](#)).

Authorization must be renewed every six months (180 days) and every time there is a change in prescription.

The JV-220 is one legal and practical measure the state is taking to address the urgent need to prevent and reduce harm caused by inappropriate use of psychotropic medications by monitoring medication use at systemic and individual case level ([ACIN No. I-36-15](#)). At the systems level, and as a result of the [Global Data Sharing Agreement](#), counties will receive medical information from the JV-220 that will be used to identify and flag prescribing characteristics that pose the most health risk to children and youth in their care ([ACIN No. I-36-15](#)). The data sharing will help identify trends and differences among counties and regions with regard to medication usage. At the individual case level for example, the JV-220 will be compared with the child's Health Information Passport (HEP) from CWS/CMS so that doctors can have a holistic view of the child's medical history and identify all medications used and their possible side effects on the child (Bullard, Davis, Moore, & Morris, 2013). It is therefore important that social workers verify that the JV-220 is completed, dated, and renewed on a timely basis.

Further the JV-222 attachment form gives social workers, and all members of the child's professional and personal team, the opportunity to advocate, and if necessary, oppose the administrations of these medications.

During an emergency and life threatening situation a child may be prescribed psychotropic medications before authorization is granted. However documentation requesting authorization needs to be processed immediately (see [Appendix D](#) in the [California Guidelines, 2015](#) for more detailed guidelines for prescribing and authorizing psychotropic medications during an emergency situation).

Madera County released a comprehensive policy and procedure guide that describes step-by-step with specific tasks, what medical, judicial stakeholders, and social workers need to do to complete and process the JV-220 protocol. [Madera's guidelines](#) serve as a check list tool to help clarify task expectations for professional psychotropic medication stakeholders and support medication oversight in the county.

Psychosocial and Psychotropic Medication Treatment Plan

As a coordinating team member social workers should have an understanding of the different phases in the child's clinical treatment plan to clarify expectations, help anticipate needs, and to have a working knowledge to communicate with the medical team, the child, and caregivers while staying within their scope of knowledge and practice. A child's mental health treatment plan must be individualized and comprehensive based on a trauma-informed diagnosis and treatment strategies. It must incorporate psychosocial intervention, with some situational exceptions, and include FDA approved psychotropic medication as one element of the treatment plan (California State Guidelines, 2015).

Trauma-Informed Care and Psychosocial Interventions

The [California Guidelines, 2015](#) reiterate the [Public Law 112-34](#) requirement which states that Title IV-B agencies must address the issue of emotional trauma as part of a

comprehensive mental health treatment plan. The guidelines further recognize the SAMHSA (Substance Abuse and Mental Health Services Administration) definition of Trauma.

“Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual’s functioning and physical, social emotional, or spiritual well-being.”

The goal of trauma-informed interventions is to ameliorate the child’s trauma-related symptoms associated with removal from the home and the neglect or abuse that brought the child into custody. Interventions should help foster and build the child’s resilience by capitalizing on the child’s or youth’s own social emotional protective capacities. Social workers can encourage the child’s social emotional growth by finding and advocating for personal growth opportunities that are of interest to the child such as sports activities, dance, arts, and music and by encouraging positive attachment with mentors, coaches, and caregivers.

According Griffin et al. (2011) a thorough assessment and understanding of the impact of trauma in the child’s life needs to come before a child receives a diagnosis. They explain that some symptoms from childhood trauma and mental health illnesses overlap or can occur together making it difficult to decipher if a child is suffering from trauma, mental health illness or both. For example restlessness, hyperactive symptoms from attention deficit hyperactivity disorder (ADHD) and anger outbursts from oppositional defiant disorder (ODD) can also be symptoms of child trauma (Griffin, et al., 2011).

Psychotropic Medication Treatment

AACAP (2009) describes psychotropic medication treatment in three phases: The *acute phase* is the initial period when a psychotropic medication is introduced, and its dosage is slowly adjusted to maximize benefits and reduce risk; the *maintenance phase* is the period in which a child is under remission and recovery; the *discontinuation phase* is the process by which medications are slowly tapered to reduce the risk of relapse and end medication dependency.

[Appendix A](#) from the [California Guidelines, \(2015\)](#) provides standards of psychotropic medication use by age group intended for the court. It gives a summary of allowable psychotropic medications by age group. Social workers can review these standards to develop an awareness of what might be considered safe or unsafe prescriptions and also to check for discrepancies.

[Appendix D](#) provides a list of questions and considerations to make before prescribing, when prescribing, when a child has received previous medications and when prescribing during an emergency situation. Social workers can review this list to become familiar with information needed to think critically about the child’s mental health care services. Some examples in the [California Guidelines, \(2015\)](#) include the following considerations:

- Might the existing treatment be exacerbating the child’s behavior?
- Are there environmental factors, e.g., in the placement or school setting that could or should be addressed first?
- Treatment with a single medication for a single symptom or disorder should be tried before treatment with multiple medications is considered.

- What is the child's or youth's perspective regarding medication? Does the child or youth state that the medication is helpful?

[Appendix C](#) of the California State Guidelines provides a list of expected challenges in psychiatric diagnosis and recommendations for medication use. Social workers can use this as a reference to check for treatment practices that should be avoided to ensure children and youth are kept safe. For example, in the case of adding or changing two or more medications simultaneously such as in polypharmacy, only one change should occur at a time, except in rare circumstances.

Social workers are encouraged to understand the different types of medications, their targeted diagnosis, dosages, known side effects and concerns, and methods of administration. California adopted Parameters 3.8 for Use of Psychotropic Medications in Children and Adolescents particularly to guide public health nurses and prescribing physicians (The parameters are found in [Appendix B](#) of the California psychotropic medication guidelines). Texas Department of Family and Protective Services (DFPS), in collaboration with University of Texas at Austin College of Pharmacy, released their [Psychotropic Medication Utilization Parameters for Children and Youth in foster Care](#), which provides user-friendly tables social workers without a medical background can use. The tables break down psychotropic medication by class and targeted diagnosis treatment with a list of most commonly used prescriptions, initial and maximum dosage, warnings, and other considerations regarding their use.

Monitoring

While psychotropic medications can provide relief to children and youth suffering from mental conditions, they also present a potential health risk to the children youth taking them. Careful monitoring, in consultation with the prescriber and in collaboration with the caregiver administering the medication to the child, is essential to reduce potential harmful side effects ([California Guidelines, 2015](#)).

Further, social workers should continually ensure that there is a shared understanding of what medication is being prescribed; its targeted symptoms; its dosage and schedule; expected changes; side effects; and other important considerations.

Cohen and Sengelman (2008) through Critical ThinkRx provide a [medication monitoring check list](#) social workers can use with foster parents. The check list helps monitor emergent effects the medication might have on a child's psychological and physical wellbeing. Critical ThinkRx recommends the check list be used before medications are administered to record a child's emotional, cognitive, and psychical baseline, when taking medication to monitor effects, then after medications are discontinued. The check list enables the monitoring person to score, for example, if the child seems confused, irritable, or has gained weight on a 3-point scale with 1 being mild, 2 moderate, and 3 severe.

Hughes and Cohen (2010) further state that more research on the effects of psychotropic medication is needed, particularly research that includes observations made by individuals who know and regularly interact with the child or youth. This is because, unlike clinical trial researchers, social workers and caregivers spend more time with the child and are better able to recognize changes in physical and psychological wellbeing (Hughes & Cohen, 2010).

Psychotropic Medication Discontinuation Plan

An assessment and monitoring plan to discontinue the use of psychotropic medication needs to be developed by physician with considerations of the child's unique circumstances.

Social workers must again consult with physicians or public health nurses and collaborate with caregivers to clarify why medications are being discontinued and how this process will be conducted.

AACAP (2009) states three reasons for discontinuing medication: the child has recovered and no longer needs medication; the child has an adverse reaction to medication; and the physician, child, or adolescent does not find the medication effective. AACAP (2009) further recommends a gradual tapering off of the medication for most cases to reduce withdrawal symptoms and relapse.

Conclusion

Social workers and other professional team members, at different levels of responsibility and knowledge, play a role in ensuring safety measures are followed and discrepancies are resolved to optimize health care outcomes for the child. Child welfare social workers, following guidelines and protocols, consult with all team members to develop a shared understanding of the child's circumstances, clarify shared action expectations, and determine health care goals. This review provided general guidelines, policies, and procedures to assist social workers when developing plans to deliver services to children and youth using psychotropic medication. However, it is not all inclusive, so social workers must review policies and guidelines and consult with supervisors, public health nurses, psychiatrists, care providers, and county counsel to obtain a clearer understanding of expectations in mental health care coordination.

Bibliography

Administration for Children & Families, U.S. Department of Health and Human Services, Information Memorandum: Oversight of Psychotropic Medication for Children in Foster Care: Title IV-B Health Care Oversight & Coordination Plan, ACYF-CB-IM-12-03 (April 11, 2012)

American Academy of Child and Adolescent Psychiatry. (January 1, 2009). Practice parameter on the use of psychotropic medication in children and adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 48, 9, 961–73.

Breggin, P.R. (2000). Dr. Breggin Testifies before U.S. Congress. Retrieved September 21, 2015 from http://breggin.com/index.php?option=com_content&task=view&id=80

Breggin, P.R. (1999). Psychostimulants in the treatment of children diagnosed with ADHA: Part 1:- Acute risks and psychological effects. *Ethical Human Sciences and Services*, Vol. 1 (21), 13–33.

Breggin, P.R. (1999c). Psychostimulants in the treatment of children diagnosed with ADHD: Risks and mechanism of action. *International Journal of Risk and Safety in Medicine*, 12, 3–35. By special arrangement, this report was originally published in two parts by Springer Publishing Company in Ethical Human Sciences and Services (Breggin 1999a&b).

Bullard, S., Davis, A., Moore, S., & Morris, D. (2013, April 17). *Collaborative approach to deciding if and when to issue and monitor psychotropic medication [Webinar]*. UC Davis Extension for Human Services. Archived Webinar. Retrieved June 30, 2015 from <http://humanservices.ucdavis.edu/Resource/FamilyFocused/InThisSection/AchivedWebinars.aspx>

California Department of Social Services. All County Information Notice No. I-30-15 (May 1, 2015). Health and Human Services Agency. Retrieved September 21, 2015 from <http://www.dss.cahwnet.gov/lettersnotices/PG3679.htm>

California, Department of Social Services and Department of Health Care Services, Foster Care Quality Improvement Project. (2015). California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care. Retrieved June 1, 2015, from <http://www.dhcs.ca.gov/provgovpart/Documents/PharmacyBenefits/QIPFosterCare/Clinical/Deliver/Guidelines.pdf>

Crismon, M. L., & Argo, T. (2009). The use of psychotropic medication for children in foster care. *Child Welfare*, 88(1), 71–100

Cohen, D., & Sengelman, I. (2008). Critical ThinkRx: A critical curriculum on psychotropic medications. Retrieved July 15, 2015, from www.criticalthinkrx.org

de Sá, K. (2014, August 24). Drugging our Kids. *San Jose Mercury News*. Available at: <http://webspecial.mercurynews.com/druggedkids/?page=pt1>

dosReis, S., Yoon, Y., Rubin, D. M., Riddle, M. A., Noll, E., & Rothbard, A. (2011). Antipsychotic treatment among youth in foster care. *Pediatrics*, 128(6), e1459–e1466. doi:10.1542/peds.2010-2970

Griffin, G., McClelland, G., Holzberg, M., Stolbach, B., Maj, N., & Kisiel, C. (January 01,

2011). Addressing the Impact of Trauma before Diagnosing Mental Illness in Child Welfare. *Child Welfare*, 90, 6, 69-89.

Grimm, B. (n.d.). PsychDrugs Action Campaign. A key concept for psychotropic drug reform: "What gets measured gets done." Retrieved June 3, 2015, from <http://childpsychdrugsafety.org/a-key-concept-for-psychotropic-drug-reform-what-gets-measured-gets-done>

Hayek, M., Mackie, T. I., Mulé, C. M., Bellonci, C., Hyde, J., Bakan, J. S., & Leslie, L. K. (2013). A multi-state study on mental health evaluation for children entering foster care. *Administration and Policy in Mental Health and Mental Health Services Research Adm Policy Ment Health*, 41(4), 552–567. doi:10.1007/s10488-013-0495-3

Hughes, S., & Cohen, D. (January 1, 2010). Understanding the assessment of psychotropic drug harms in clinical trials to improve social workers' role in medication monitoring. *Social Work*, 55, 2, 105–15.

Leslie, L. K., Raghavan, R., Hurley, M., Zhang, J., Landsverk, J., & Aarons, G. (2011). Investigating geographic variation in use of psychotropic medications among youth in child welfare. *Child Abuse & Neglect*, 35(5), 333–342. <http://doi.org/10.1016/j.chab.2011.01.012>

Longhofer, J., Floersch, J., & Okpych, N. (February 01, 2011). Foster youth and psychotropic treatment: Where next?. *Children and Youth Services Review*, 33, 2, 395-404.

Mackie, T. I., Hyde, J., Rodday, A. M., Dawson, E., Lakshmikanthan, R., Bellonci, C., Leslie, L. K. (2011). Psychotropic medication oversight for youth in foster care: A national perspective on state child welfare policy and practice guidelines. *Children And Youth Services Review*, 33(11), 2213–2220. <http://doi.org/10.1016/j.childyouth.2011.07.003>

Moses, T., & Kirk, S. A. (January 1, 2006). Social workers' attitudes about psychotropic drug treatment with youths. *Social Work*, 51, 3, 211–22.

National Survey of Child and Adolescent Well-Being, No. 17: Psychotropic medication use by children in child welfare. (2012). *PsycEXTRA Dataset*. doi:10.1037/e565682012-001

Raghavan, R., Lama, G., Kohl, P., & Hamilton, B. (2010). Interstate variations in psychotropic medication use among a national sample of children in the child welfare system. *Child Maltreatment*, 15(2), 121–131. <http://doi.org/10.1177/1077559509360916>

Raghavan, R., Zima, B. T., Andersen, R. M., Leibowitz, A. A., Schuster, M. A., & Landsverk, J. (January 01, 2005). Psychotropic medication use in a national probability sample of children in the child welfare system. *Journal of Child and Adolescent Psychopharmacology*, 15, 1, 97–106.

Sheldon, G., Berwick, D., & Hyde, P. (2011). Joint Letter to State Child Welfare, Medicaid, and Mental Health Authorities on the Use of Psychotropic Medication for Children in Foster Care. Administration for Children and Families, Centers for Medicare and Medicaid Services, & Substance Abuse and Mental Health Services Administration. Washington D.C. Available at: <https://childwelfare-stage.icfwebservices.com/systemwide/mentalhealth/effectiveness/jointlettermeds.pdf>

Safer, D. J., Rajakannan, T., Burcu, M., & Zito, J. M. (2015). Trends in subthreshold psychiatric

diagnoses for youth in community treatment. *JAMA Psychiatry*, 72(1), 75. doi:10.1001/jamapsychiatry.2014.1746

Texas Department of Family and Protective Services (DFPS) and the University of Texas at Austin College of Pharmacy. (2013). Psychotropic Medication Utilization Parameters for Children and Youth in foster Care. Retrieved September 21, 2015 from https://www.dfps.state.tx.us/Child_Protection/Medical_Services/documents/pdf/TxFosterCareParameters.pdf

U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau (2012). Making healthy choices: A guide on psychotropic medications for youth in foster care. Washington, D.C.: Author. Retrieved September 21, 2015 from <https://www.childwelfare.gov/pubs/makinghealthychoices/>

U.S. Government Accountability Office. (2011). Foster children: HHS guidance could help states improve oversight of psychotropic medication (Publication No. GAO-12-270T). Washington, D.C.: Author. Document Number)

Wilson, D. (2009, September 11). Poor children likelier to get antipsychotics. *New York Times* from http://www.nytimes.com/2009/12/12/health/12medicaid.html?_r=3&pagewanted=all

Zito, J. M., Safer, D. J., Sai, D., Gardner, J. F., Thomas, D., Coombes, P., Mendez-Lewis, M. (2008). Psychotropic medication patterns among youth in foster care. *Pediatrics*, 121(1). <http://doi.org/10.1542/peds.2007-0212>

Appendix

Harmful Stimulant Effects Commonly Misidentified as 'Therapeutic' or 'Beneficial' for Children Diagnosed with ADHD

OBSESSIVE COMPULSIVE EFFECTS	SOCIAL WITHDRAWAL EFFECTS	BEHAVIORALLY SUPPRESSIVE EFFECTS
<ul style="list-style-type: none"> • Compulsive persistence at meaningless activities (called stereotypical or perseverative behavior) • Increased obsessive compulsive behavior (e.g., repeating chores endlessly and ineffectively) • Mental rigidity (called cognitive perseveration) • Inflexible thinking • Overly narrow or excessive focusing 	<ul style="list-style-type: none"> • Socially withdrawn and isolated • General dampened social behaviour • Reduced communicating or socializing • Decreased responsiveness to parents and other children • Increased solitary play and diminished overall play 	<ul style="list-style-type: none"> • Compliant in structured environments; socially inhibited, passive and submissive • Sombre, subdued, apathetic, lethargic, drowsy, dopey, dazed, and tired • Bland, emotionally flat, humourless, not smiling, depressed, and sad with frequent crying • Lacking in initiative or spontaneity, curiosity, surprise or pleasure

Note. Adapted from Psychostimulants in the treatment of children diagnosed with ADHD: Risks and mechanism of action. *International Journal of Risk and Safety in Medicine*, 12, 3-35, by P.R. Breggin, (1999), Springer Publishing Company in Ethical Human Sciences and Services (Breggin 1999a&b).

Symptoms that Overlap with Child Trauma and Mental Illness

MENTAL ILLNESS	OVERLAPPING SYMPTOMS	TRAUMA
Attention deficit/hyperactivity disorder(ADHD)	Restless, hyperactive, disorganized, and/or agitated activity; difficulty sleeping, poor concentration, and hypervigilant motor activity	Child trauma
Oppositional defiant disorder (ODD)	A predominance of angry outbursts and irritability	Child trauma
Anxiety disorder (incl. social anxiety), obsessive-compulsive disorder (OCD), generalized anxiety disorder(GAD), or phobia	Avoidance of feared stimuli, physiologic and psychological hyperarousal upon exposure to feared stimuli, sleep problems, hypervigilance, and increased startle reaction	Child trauma
Major depressive disorder (MDD)	Self-injurious behaviors as avoidant coping with trauma reminders, social withdrawal,	Child trauma

	affective numbing, and/or sleeping difficulties	
Bipolar Disorder	Hyperarousal and other anxiety symptoms mimicking hypomania; traumatic reenactment mimicking aggressive or hypersexual behavior; and maladaptive attempts at cognitive coping mimicking pseudo-manic statements	Child trauma
Panic Disorder	Striking anxiety and psychological and physiologic distress upon exposure to trauma reminders and avoidance of talking about the trauma	Child trauma
Substance Abuse Disorder	Drugs and/or alcohol used to numb or avoid trauma reminders	Child trauma
Psychotic Disorder	Severely agitated, hypervigilance, flashbacks, sleep disturbance, numbing, and/or social withdrawal, unusual perceptions, impairment of sensorium and fluctuating levels of consciousness.	Child trauma

Note. Adapted from addressing the impact of trauma before diagnosing mental illness in child welfares. *International*, by Griffin, et al. (2011), *Child Welfare*, 90(6), 69–89.