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A Federal Solution to Foster Care's Psychotropic Drug Crisis

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A FEDERAL SOLUTION TO FOSTER CARE'S PSYCHOTROPIC DRUG CRISIS

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INTRODUCTION

Psychotropic drugs are a type of medication designed to influence mood and behavior by altering chemical levels in the brain.[1] The Food and Drug Administration (FDA) typically approves these drugs for use in adults, but doctors are free to prescribe them in whichever way their medical judgment directs.[2] When doctors prescribe an approved drug for an unapproved use, they are engaging in "off-label" prescribing.[3] It is estimated that up to 75% of psychotropic medication use in children is off-label.[4] Off-label use exposes children to a drug's side effects without assurance that the drug will effectively treat the condition for which it has been prescribed.[5] In fact, it has been observed that children "just don't get the robust benefit that many adults get" from treatment with psychotropic medication.[6] Little is known about how psychotropic drugs affect children in the short or long term, as liability issues often prevent funding of clinical trials involving children,[7] and the results of adult

1. Enjoli Francis, *Psychotropic Drugs: What Are They?*, ABC NEWS MED. UNIT (Dec. 2, 2011, 5:04 PM), http://abcnews.go.com/blogs/health/2011/12/02/what-you-need-to-know-about-psychotropic-drugs/.

2. C. Lindsay Devane, *Off-Label Prescribing of Drugs in Child and Adolescent Psychiatry*, *in* PHARMACOTHERAPY OF CHILD AND ADOLESCENT PSYCHIATRIC DISORDERS 25, 25–26 (David R. Rosenberg & Samuel Gershon eds., 3d ed. 2012).

3. *Id.*

4. Rick Nauert, *Psychotropic Medications Overused Among Foster Children*, PSYCHCENTRAL (Aug. 4, 2008), http://psychcentral.com/news/2008/08/04/psychotropic-medications-overused-among-foster-children/2688.html#.UrzBK7R5jCc.

5. *See* David Rubin et al., *Interstate Variation in Trends of Psychotropic Medication Use Among Medicaid-Enrolled Children in Foster Care*, 34 CHILD. & YOUTH SERVS. REV. 1492, 1493 (2012) (describing the controversy surrounding the use of atypical antipsychotics in children, given limited evidence of efficacy and emerging concerns about side effects).

6. Virginia Merritt, *View from the "Other Side": Why Child Psychiatrists Hate the* Rogers *Decision*, MASS. OFFICE OF THE CHILD ADVOCATE 14 (Aug. 8, 2000), http://www.mass.gov/childadvocate/docs/mcle-rogers-paper-dr-virginia-merritt.doc.

7. JOANNE SOLCHANY, PSYCHOTROPIC MEDICATION AND CHILDREN IN FOSTER CARE: TIPS FOR ADVOCATES AND JUDGES 1, 14 (2011), *available at* http://

studies cannot be extrapolated to children.[8] Best medical practice requires limiting the prescription of psychotropic medication to children to avoid interference with development.[9]

Psychotropic drugs are grouped into five classes: antidepressants, antianxiety drugs, mood stabilizers, antipsychotics, and stimulants.[10] Of most concern are antipsychotics, which are further divided into typical and atypical subtypes. Atypical antipsychotics, which the FDA has approved to treat severe illnesses like schizophrenia, are increasingly prescribed to address disruptive behaviors in children.[11] They have several dangerous side effects, including

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www.americanbar.org/content/dam/aba/administrative/child_law/PsychMed.authcheckdam.pdf; M. Lynn Crismon & Tami Argo, *The Use of Psychotropic Medication for Children in Foster Care*, 88 CHILD WELFARE 71, 73 (2009); Merritt, *supra* note 6, at 16.

8. MEDICAID MED. DIRS. LEARNING NETWORK & RUTGERS CTR. FOR EDUC. & RESEARCH ON MENTAL HEALTH THERAPEUTICS, ANTIPSYCHOTIC MEDICATION USE IN MEDICAID CHILDREN AND ADOLESCENTS: REPORT AND RESOURCE GUIDE FROM A 16-STATE STUDY 12 (2010) [hereinafter RUTGERS STUDY], *available at* http://rci.rutgers.edu/~cseap/MMDLNAPKIDS/Antipsychotic_Use_in_Medicaid_Children_Report_and_Resource_Guide_Final.pdf; *see also* MELISSA D. CARTER, GEORGIA PSYCHOTROPIC MEDICATION MONITORING PROJECT 19 (2012), *available at* http://bartoncenter.net/uploads/PsychMedsProject/GAPsychotropicMedMonitoProjReport_FINAL.pdf ("[C]hildren have adverse reactions [to psychotropic drugs] that differ from adult reactions, depending on the maturity of their organ and metabolic systems."); Christopher Bellonci & Tricia Henwood, *Use of Psychotropic Medications in Child Welfare*, NAT'L RESOURCE CENTER FOR PERMANENCY & FAMILY CONNECTIONS 10, http://www.hunter.cuny.edu/socwork/nrcfcpp/downloads/ppt/Psychotropic-Medications.ppt (last visited Nov. 2, 2014) (listing "[m]edications that were safe for use in adults that had unanticipated side-effects for children").

9. 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, 467 (2010); Mary Margaret Gleason et al., *Psychopharmacological Treatment for Very Young Children: Contexts and Guidelines*, 46 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 1532, 1535 (2007); *see also* CAROLE KEETON STRAYHORN, TEXAS HEALTH CARE CLAIMS STUDY—SPECIAL REPORT ON FOSTER CHILDREN 76 (2006) [hereinafter STRAYHORN, TEXAS HEALTH CARE CLAIMS STUDY], *available at* http://psychrights.org/states/Texas/hccfoster06.pdf (noting that caution is recommended because the effects of psychotropic drugs on "learning, cognition, growth, and development" are unknown); Mark Abdelmalek et al., *New Study Shows U.S. Government Fails to Oversee Treatment of Foster Children with Mind-Altering Drugs*, ABC NEWS (Nov. 30, 2011), http://abcnews.go.com/US/study-shows-foster-children-high-rates-prescription-psychiatric/story?id=15058380&singlePage=true ("The general consensus is that when you're treating young children, you always try behavioral intervention before you go to medication.").

10. *Categories of Psychiatric Medications*, STANFORD SCH. OF MED., http://whatmeds.stanford.edu/medications/categories.html (last visited Jan. 13, 2014).

11. SHEILA A. PIRES ET AL., FACES OF MEDICAID: EXAMINING CHILDREN'S BEHAVIORAL HEALTH SERVICE UTILIZATION AND EXPENDITURES 61 (2013) (claiming that

rapid weight gain, type 2 diabetes, menstrual irregularities, pituitary tumors, liver function abnormalities, and irreversible facial tics.[12] Consequently, atypical antipsychotics are generally considered a last resort, to be used only after non-pharmaceutical interventions like therapy have been tried and found inadequate.[13]

Recent years have seen a general increase in the number of children treated with psychotropic drugs, but children in foster care have been particularly vulnerable to this trend.[14] This Note will begin by exploring the roots and extent of foster care's psychotropic medication crisis. It will then endorse a system of child welfare agency consent with "red flag" preconsent review as the best possible solution. It concludes by proposing that the federal government address this crisis by conditioning state access to federal funds on the use of red flag preconsent review.

I.
PRESSURES TO MEDICATE

Foster care's overreliance on psychotropic drugs can be traced to the fact that there are more pressures to medicate foster children than there are pressures against medicating them. Among the pressures to medicate are the foster child's behavior, the lack of a consistent interested party in the foster child's life, the growing number of primary care doctors prescribing psychotropic medication, the influence of drug manufacturers, a lack of patience or funds for alternative treatments, and the attitudes of foster parents and school personnel.

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atypical antipsychotics are "often used off-label for their sedating side effects"); Sandra G. Boodman, *Off-Label Use of Risky Antipsychotic Drugs Raises Concerns*, KAISER HEALTH NEWS (Mar. 12, 2012), http://www.kaiserhealthnews.org/stories/2012/march/13/off-label-use-of-risky-antipsychotic-drugs.aspx (interviewing a pediatrician who observed that antipsychotics "were typically prescribed to children to control disruptive behavior"); Rosanne Spector, *Evidence Lacking for Widespread Use of Costly Antipsychotic Drugs, Says Researcher*, INSIDE STANFORD MED. (Jan. 6, 2011), http://med.stanford.edu/ism/2011/january/antipsychotics.html (noting that atypical antipsychotics were originally approved to treat schizophrenia).

12. STRAYHORN, TEXAS HEALTH CARE CLAIMS STUDY, *supra* note 9, at vii; Spector, *supra* note 11.

13. Crismon & Argo, *supra* note 7, at 77.

14. *See* PIRES ET AL., *supra* note 11 ("Overall psychotropic medication use has increased two- to three-fold in the past 10 years, including among the very young and among privately insured children.").

A. The Foster Child's Behavior

Several factors converge to increase the likelihood that children in foster care will exhibit challenging behaviors. They may have suffered neglect or abuse at the hands of their biological parents, causing them lasting emotional damage.[15] They may also have family histories of mental illness, raising the risk that they themselves will suffer from mental illness.[16] Most significantly, many have been separated from their families of origin and placed with strangers. The trauma associated with separation can create feelings of sadness, rage, or fear that lead foster children to suffer from behavioral disturbances.[17]

Trouble arises when doctors try to affix a diagnostic label to these feelings and behaviors. Doctors observing foster children may mistake normal emotional reactions to neglect, abuse, or separation for signs of a psychiatric disorder.[18] Lack of access to a foster child's family or medical history exacerbates this problem. One child and adolescent psychiatrist, remarking on the difficulties of evaluating foster children, noted that doctors must often make de-

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15. *See* ADVISORY COMM. ON PSYCHOTROPIC MEDICATIONS, TEX. DEP'T OF FAMILY & PROTECTIVE SERVS., THE USE OF PSYCHOTROPIC MEDICATIONS FOR CHILDREN AND YOUTH IN THE TEXAS FOSTER CARE SYSTEM 25 (2004), *available at* http://www.dfps.state.tx.us/documents/Child_Protection/pdf/Advisory_Committe_Report_on_Psych_Meds_Sept_2004.pdf (expressing concern that "there will be an over-reliance upon medications to control the child's behaviors that stem from . . . abuse or neglect").

16. *See* N.Y. OFFICE OF CHILDREN & FAMILY SERVS., INFORMATIONAL LETTER NO. 08-OCFS-INF-02, THE USE OF PSYCHIATRIC MEDICATIONS FOR CHILDREN AND YOUTH IN PLACEMENT—AUTHORITY TO CONSENT TO MEDICAL CARE (Feb. 13, 2008), *available at* http://ocfs.ny.gov/main/policies/external/OCFS_2008/INFs/08-OCFS-INF-02%20The%20Use%20of%20Psychiatric%20Medications%20for%20Children%20and%20Youth%20in%20Placement%20-%20Authority%20to%20Consent%20to%20Medical%20Care.pdf ("Children in care often have biological . . . risk factors that predispose them to emotional and behavioral disturbances.").

17. Editorial, *The Drugging of Foster Youth*, SFGATE (June 11, 2006), http://www.sfgate.com/opinion/editorials/article/The-drugging-of-foster-youth-2494981.php.

18. *See* PHARMACY & THERAPEUTICS COMM., TENN. DEP'T OF CHILDREN'S SERVS., PSYCHOTROPIC MEDICATION UTILIZATION PARAMETERS FOR CHILDREN IN STATE CUSTODY 2, *available at* http://www.tn.gov/youth/dcsguide/policies/chap20/PsychoMedUtilGuide.pdf (noting that foster children often exhibit symptoms "reflective of past traumatic and reactive attachment difficulties" that "mimic many overlapping psychiatric disorders"); ADMIN. FOR CHILDREN & FAMILIES, U.S. DEP'T OF HEALTH & HUMAN SERVS., IM-12-03, PROMOTING THE SAFE, APPROPRIATE, AND EFFECTIVE USE OF PSYCHOTROPIC MEDICATION FOR CHILDREN IN FOSTER CARE 4 (Apr. 11, 2012), *available at* https://www.acf.hhs.gov/sites/default/files/cb/im1203.pdf ("Children in foster care are more likely to have a mental health diagnosis than other children.").

cisions as to diagnosis and treatment based on behavioral symptoms alone.[19] The end result is the unnecessary medication of many "fundamentally normal children" who are simply reacting to extraordinary events in their lives.[20]

B. Lack of a Consistent Interested Party

Overuse of psychotropic drugs can also be attributed to the lack of a consistent interested party in the lives of most foster children. The presence of an adult who could observe the child's behavior, accompany the child to medical appointments, provide or withhold consent to treatment with psychotropic drugs, and monitor the effects of such drugs would go a long way toward stemming the crisis.[21] Unfortunately, most foster children "have no natural advocates or allies."[22] Their biological parents are frequently uninvolved in their lives, either by choice or otherwise; their caseworkers are overburdened and unable to invest significant resources in any one child; and many foster children are unable to establish meaningful relationships with substitute caretakers due to frequent placement changes.[23] The risk of overmedication is at its highest when none of the adults involved in a foster child's care takes full responsibility for the child's welfare.[24]

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19. *The Watch List: The Medication of Foster Children* (PBS television broadcast Jan. 7, 2011) (interviewing Dr. Fernando Siles, Child & Adolescent Psychiatrist), *available at* http://www.pbs.org/wnet/need-to-know/health/video-the-watch-list-the-medication-of-foster-children/6232/.

20. CAROLE KEETON STRAYHORN, FORGOTTEN CHILDREN 199 (2004) [hereinafter STRAYHORN, FORGOTTEN CHILDREN]; *see also* Burton, *supra* note 9, at 495 (claiming that children in foster care are likely to be prescribed psychotropic medication to control "feelings that are not excessive or out of proportion to the child's real life experiences"); David Crary, *A Dilemma: Medications for Foster Kids*, BOSTON.COM (Mar. 13, 2007), http://www.boston.com/news/nation/articles/2007/03/13/a_dilemma_medications_for_foster_kids/ ("Children who are having normal reactions to the trauma of being separated from their families are often misdiagnosed or overdiagnosed as suffering from psychiatric problems.").

21. Tracy Weber, *Caretakers Routinely Drug Foster Children*, L.A. TIMES, May 17, 1998, http://articles.latimes.com/1998/may/17/news/mn-50808 ("The only real solution is to have social workers with caseloads of 10 kids. The thing that's missing is to have someone in the parental role. Someone who shares the child's destiny.").

22. Michelle L. Mello, Note, *Psychotropic Medication and Foster Care Children: A Prescription for State Oversight*, 85 S. CAL. L. REV. 395, 398 (2012).

23. 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, 1158 (1999).

24. *See The Financial and Societal Costs of Medicating America's Foster Children: Hearing Before the Subcomm. on Fed. Fin. Mgmt., Gov't Info., Fed. Servs. & Int'l Sec. of the S. Comm. on Homeland Sec. & Governmental Affairs*, 112th Cong. 64 (2011) [hereinaf-

C. Primary Care Physicians

Over the last decade, there has been an increase in the number of primary care physicians writing psychotropic prescriptions for foster children.[25] This phenomenon, partly attributable to a nationwide shortage of child and adolescent psychiatrists,[26] is worrisome because the typical primary care physician has little training in psychiatry.[27] Even if primary care physicians understand the risks associated with psychotropic drugs, they may be unfamiliar with the Practice Parameters issued by the American Academy of Child and Adolescent Psychiatry (AACAP).[28] The AACAP Practice Parameters are designed to guide physicians writing prescriptions for psychotropic medications. In particular, they advise on the use of multiple psychotropic drugs in one patient, or polypharmacy,[29] and give detailed recommendations on how best to monitor side effects.[30] Because primary care physicians are unlikely to understand the complex considerations that should go into prescribing a psychotropic drug, they are not only more likely to prescribe in the first

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ter *2011 Hearing*] (statement of Gregory D. Kutz, Director of Forensic Audits & Investigative Services) (observing that foster children lack "a consistent caretaker to plan treatment, offer consent, and provide oversight"); Laurel K. Leslie et al., *States' Perspectives on Medication Use for Emotional and Behavioral Problems among Children in Foster Care*, NAT'L RESOURCE CENTER FOR PERMANENCY & FAMILY CONNECTIONS 4 (Feb. 2010), http://nrcpfc.org/teleconferences/2-10-10/L%20Leslie%20medication%20powerpoint.ppt (claiming that the psychotropic drug problem is exacerbated by the "lack of a designated, consistent individual . . . to monitor [the foster child's] care").

25. *See Are Too Many Kids Taking Antipsychotic Drugs?*, CONSUMER REPORTS (Dec. 2013), http://www.consumerreports.org/cro/2013/12/are-too-many-kids-taking-antipsychotic-drugs/index.htm ("The number of prescriptions for [antipsychotic] drugs written by pediatricians has increased steadily over the last several years and is up nearly 25 percent since 2006.").

26. Crary, *supra* note 20.

27. Brandow, *supra* note 23, at 1175; Weber, *supra* note 21.

28. AM. ACAD. OF CHILD & ADOLESCENT PSYCHIATRY, PRACTICE PARAMETERS FOR THE USE OF ATYPICAL ANTIPSYCHOTIC MEDICATIONS IN CHILDREN AND ADOLESCENTS (2011) [hereinafter AM. ACAD. OF CHILD & ADOLESCENT PSYCHIATRY, PRACTICE PARAMETERS], *available at* http://www.aacap.org/App_Themes/AACAP/docs/practice_parameters/Atypical_Antipsychotic_Medications_Web.pdf; *see also* Brandow, *supra* note 23, at 1175 (emphasizing that "general practitioners . . . may not have sufficient specialized training" in psychiatry).

29. AM. ACAD. OF CHILD & ADOLESCENT PSYCHIATRY, PRACTICE PARAMETERS, *supra* note 28, at 12.

30. *Id.* at 12–14.

place, but also more likely to prescribe combinations of medications and less likely to properly monitor side effects.[31]

D. Drug Manufacturers

The problem of improper use of psychotropics does not disappear even when a child and adolescent psychiatrist writes the prescription. Pharmaceutical companies' marketing techniques pressure doctors of all kinds into writing unnecessary prescriptions.[32] The influence of manufacturers can be seen in the studies evaluating the efficacy of new drugs. By funding these studies themselves or training sales representatives to spin study results in the most positive light, pharmaceutical companies routinely mislead doctors into believing that drugs are less dangerous and more effective than the available evidence warrants.[33] In the most severe cases, drug manufacturers give kickbacks to doctors who prescribe their products.[34]

Psychotropic drugs, especially antipsychotics, have become particularly important moneymakers for pharmaceutical companies. Annual U.S. sales of antipsychotics rose from $2.8 billion in 2003 to $18.2 billion in 2011.[35] The growing popularity of these drugs is

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31. Mark Olfson et al., *National Trends in the Office-Based Treatment of Children, Adolescents, and Adults with Antipsychotics*, 69 ARCH. GEN. PSYCHIATRY 1247, 1254 (2012) (linking an increase in antipsychotic use among children and adolescents to prescriptions by "nonpsychiatrist physicians"); Boodman, *supra* note 11 (attributing the misuse of antipsychotics to "the growing number of non-psychiatrists prescribing them"); *see also* KAREN WORTHINGTON, PSYCHOTROPIC MEDS FOR GEORGIA YOUTH IN FOSTER CARE: WHO DECIDES? 3 (2011), *available at* http://www.ct.gov/dcf/lib/dcf/behavorial_health_medicine/pdf/georgia_article_foster_care.pdf (arguing that the dearth of evidence on the long-term effects of psychotropic medication "dictate[s] . . . specialized expertise when it comes to giving medications to children").

32. Ellen L. Blank & D. Micah Hester, *Industry Representatives, Gift-Giving, and Conflicts of Interest*, *in* CLINICAL ETHICS IN PEDIATRICS 215, 216 (Douglas S. Diekema et al. eds., 2011) (reporting that "multiple studies have shown that the prescribing practices of both residents and veteran practitioners are affected by [the marketing] practices of the medical industry").

33. *See* Michael Sernyak & Robert Rosenheck, *Experience of VA Psychiatrists with Pharmaceutical Detailing of Antipsychotic Medications*, 58 PSYCHIATRIC SERVICES 1292, 1295–96 (2007) (concluding that some assertions made by sales representatives were inconsistent with FDA-approved package inserts); Boodman, *supra* note 11 (describing how marketing campaigns "affect the whole information stream" available to prescribing physicians).

34. Jessica Setless, Note, *The Crisis of Over-Medicating Children in Foster Care: Legal Reform Recommendations for New York*, 19 CARDOZO J.L. & GENDER 609, 618–20 (2013).

35. *Are Too Many Kids Taking Antipsychotic Drugs?*, *supra* note 25.

largely attributable to a surge in the number of doctors prescribing antipsychotics for off-label use.[36] One study discovered an increase from 4.4 million off-label antipsychotic prescriptions in 1995 to 9 million such prescriptions in 2008.[37] It is estimated that, for atypical antipsychotics, off-label use now accounts for the majority of prescriptions.[38]

The growth in off-label use stems from the marketing tactics of pharmaceutical companies. Proponents of off-label prescribing argue that it is necessary to the practice of child and adolescent psychiatry, given the reliability with which psychiatric disorders can be diagnosed in children and the obstacles standing in the way of conducting pediatric clinical trials.[39] It is undeniable, however, that drug manufacturers have pushed the practice of off-label prescribing past its justifiable limits. Even though the FDA prohibits manufacturers from advertising possible off-label uses of their products,[40] this rule is routinely violated; several of the major players in the atypical antipsychotics market have come under investigation for questionable marketing practices.[41]

The dangerous influence exercised by drug manufacturers is a widely recognized, but difficult to eradicate, problem. Investigations in Texas, Minnesota, and Vermont have found numerous financial ties between psychiatrists treating foster children and pharmaceutical companies.[42] Efforts to address the problem, like the Texas Medication Algorithm Project (TMAP), may become coopted by the pharmaceutical industry. TMAP, designed to aid Texas doctors through the development of a list of recommended psychotropic medications, was plagued by accusations of favoritism toward

36. *See id.* (attributing the increased popularity of antipsychotic drugs in part to pharmaceutical companies' "aggressive promotion of off-label uses in children"); *see also* Boodman, *supra* note 11 (claiming that antipsychotic drugs are often prescribed to treat "problems of living" because "doctors have gotten it into their heads that this is an acceptable use").

37. G. C. Alexander et al., *Increasing Off-Label Use of Antipsychotic Medications in the United States, 1995–2008*, 20 PHARMACOEPIDEMIOLOGY & DRUG SAFETY 177, 177 (2011).

38. Stephen Crystal et al., *Broadened Use of Atypical Antipsychotics: Safety, Effectiveness, and Policy Challenges*, 28 HEATH AFF. 770, 771 (2009).

39. Devane, *supra* note 2, at 27, 31.

40. *Id.* at 34.

41. Sernyak & Rosenheck, *supra* note 33; Spector, *supra* note 11.

42. Emily Ramshaw, *Some Texas Foster Kids' Doctors Have Ties to Drug Firms*, DALLAS MORNING NEWS, Aug. 17, 2008, http://www.mindfreedom.org/kb/youth-mental-health/foster-care-psychiatric-drugs/dallas-morning-news-texas.

companies that had supported the project and has been discontinued.[43]

E. Appeal and Availability of Alternative Treatments

Absent the influence of drug manufacturers, foster children would still face the risk of overmedication. Even assuming every participant in the sequence of events leading up to the administration of psychotropic drugs to a foster child had pure intentions, human nature as well as financial and time constraints would remain obstacles to appropriate mental health treatment.

It is human nature to choose a seemingly quick, simple solution over a slower, more difficult one. Non-pharmaceutical interventions, though demonstrated to be effective,[44] are perceived to be too time-consuming.[45] A foster child's caretakers want to see immediate changes in problematic behaviors.[46] Though a pill may carry the risk of side effects, it appears to promise instant improvement. Therapy, on the other hand, only creates gradual change.[47]

This is assuming that there is even a choice between medication and therapy. Too often, medication is the only option for adults seeking to address a foster child's mental health issues. There is a nationwide shortage of professionals qualified to administer therapy to children and adolescents: it is estimated that the United States needs 30,000 child and adolescent psychiatrists but only has 7000.[48] Even if a child and adolescent psychiatrist can be located, the doctor may refuse to accept the foster child as a pa-

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43. *The Watch List: The Medication of Foster Children*, *supra* note 19.

44. Jacqueline A. Sparks & Barry L. Duncan, *The Ethics and Science of Medicating Children*, 6 ETHICAL HUM. PSYCHOL. & PSYCHIATRY 25, 31 (2004).

45. Weber, *supra* note 21 ("The doctors don't have time to make an assessment. The fastest thing is to use chemical straitjackets on the kids . . . .").

46. *See Prescription Psychotropic Drug Use among Children in Foster Care: Hearing Before the Subcomm. on Income Sec. & Family Support of the H. Comm. on Ways & Means*, 110th Cong. 51 (2008) [hereinafter *2008 Hearing*] (statement of Misty Stenslie, Deputy Director, Foster Care Alumni of America) (arguing that "medication is used as a chemical restraint for children whose behavior get[s] out of control"); Kimber E. Strawbridge, *The Children Are Crying: The Need for Change in Florida's Management of Psychotropic Medication to Foster Children*, 15 U.C. DAVIS J. JUV. L. & POL'Y 247, 270 (2011) (lamenting that "therapy is often a secondary recommendation after prescribing a quick-fix medication to control mood and problematic behavior").

47. *See Are Too Many Kids Taking Antipsychotic Drugs?*, *supra* note 25 ("There's a societal trend to look for the quick fix, the magic bullet that will correct disruptive behaviors.").

48. *2011 Hearing*, *supra* note 24, at 160 (statement of the National Alliance on Mental Illness).

tient. Most children in foster care are insured through Medicaid,[49] and low Medicaid reimbursement rates discourage psychiatrists from treating foster children.[50] Finally, even if a foster child's caretakers succeed in finding a child and adolescent psychiatrist who accepts Medicaid, it is unlikely the doctor will provide effective nonpharmaceutical intervention. Some doctors with high caseloads will resort to drugs instead of time-consuming therapy out of necessity.[51] Others will choose the same strategy out of self-interest, recognizing that they can take on more patients by writing prescriptions than they can by offering therapy.[52] Whatever the reason, the result is the same: it is unlikely caretakers interested in therapy as an alternative to medication will be able to access that type of treatment.[53]

F. Foster Parents

Unfortunately, much of the pressure to medicate foster children comes from the adults charged with their daily care. Foster parents often bear the brunt of the child's behavioral problems and pursue psychotropic drugs as a possible solution.[54] Though some foster parents manage to forge loving bonds with their foster children, many lack the true parental concern a biological parent would possess.[55] Consequently, they are more likely to turn to psychotropic drugs to control situations that a biological parent would tolerate without pharmaceutical help.[56] They may use medi-

49. KAMALA D. ALLEN & TAYLOR HENDRICKS, MEDICAID AND CHILDREN IN FOSTER CARE 1 (2013), *available at* http://www.childwelfaresparc.files.wordpress.com/2013/03/medicaid-and-children-in-foster-care.pdf.

50. Strawbridge, *supra* note 46, at 271.

51. *See* Ramshaw, *supra* note 42.

52. *The Watch List: The Medication of Foster Children*, *supra* note 19; *see also* Crary, *supra* note 20 (claiming that psychiatrists have financial incentives to prescribe medication).

53. *See* STRAYHORN, TEXAS HEALTH CARE CLAIMS STUDY, *supra* note 9, at xiii (revealing that foster children who would benefit from therapy typically receive it inconsistently or not at all).

54. Brandow, *supra* note 23.

55. *See id.* ("While some substitute caretakers may form close emotional bonds with their foster children, many have little emotional bond with them but significant financial interest in them.").

56. *See* Strawbridge, *supra* note 46, at 267 (arguing that "foster parents . . . often do not understand the child's behavior as a parent would"); April Hunt, *Georgia Foster Kids Medicated at High Rates*, ATLANTA JOURNAL-CONSTITUTION, Feb. 23, 2011, http://www.ajc.com/news/news/local/georgia-foster-kids-medicated-at-high-rates/nQqqp/ (claiming that psychotropic drugs are often used "to make the child more docile for caregivers").

cation to sedate the child or to reduce outbursts rather than to treat a true mental illness.[57]

There are also financial incentives for foster parents to administer psychotropic drugs. Federal law requires state child welfare systems to make reimbursement payments to individuals caring for a foster child.[58] Some states make larger payments to foster parents caring for children who are taking psychotropic medications or who have been diagnosed with a mental illness.[59] Unfortunately, this has led some foster parents to needlessly medicate children in order to receive larger reimbursement payments.[60] Whether foster parents are motivated by financial concerns or are just trying to manage a child with problematic behaviors, they are likely to turn to psychotropic drugs for help.

G. School Personnel

Foster parents are not the only adults in a foster child's life who are likely to urge the use of psychotropic medication. Teachers and school officials, struggling to control a disruptive foster child, may come to view psychotropic drugs as a classroom management

57. *See* LAUREL K. LESLIE ET AL., MULTI-STATE STUDY ON PSYCHOTROPIC MEDICATION OVERSIGHT IN FOSTER CARE 4 (2010) [hereinafter LESLIE ET AL., MULTI-STATE STUDY], *available at* http://tuftsctsi.org/~/media/Files/CTSI/Library%20Files/Psychotropic%20Medications%20Study%20Report.ashx (reporting that there is "pressure from foster parents to decrease behavioral issues in order to keep children in foster homes"); STRAYHORN, FORGOTTEN CHILDREN, *supra* note 20, at 206 (presenting anecdotal evidence that foster parents seek out psychotropic medication to "make [foster children] more submissive").

58. DIANE DEPANFILIS ET AL., HITTING THE M.A.R.C. 1 (2007), *available at* http://www.childrensrights.org/wp-content/uploads/2008/06/hitting_the_marc_summary_october_2007.pdf.

59. *See, e.g.*, STRAYHORN, FORGOTTEN CHILDREN, *supra* note 20, at 206 (noting that Texas's Department of Protective and Regulatory Services provides more funding for children with greater needs).

60. *See id.* (presenting anecdotal evidence that foster parents seek out psychotropic medication to "draw down more financial reimbursement for the [foster child's] care"); A. Rachel Camp, *A Mistreated Epidemic: State and Federal Failure to Adequately Regulate Psychotropic Medications Prescribed to Children in Foster Care*, 83 TEMP. L. REV. 369, 386–87 (2011) (noting that "[p]sychotropic medications appear to be one way of qualifying for an enhanced rate of payment"); Setless, *supra* note 34, at 615 (pointing out that foster parents have a financial incentive to place the child on psychotropic medication). *But see* TEX. DEP'T OF FAMILY & PROTECTIVE SERVS., EXAMINING THE FOSTER CARE REIMBURSEMENT SYSTEM AND THE IMPACT ON THE PRESCRIBING OF PSYCHOTROPIC MEDICATION 8 (2006), *available at* http://www.dfps.state.tx.us/Documents/about/pdf/2006-10-02_Psychotropic.pdf (concluding that service level determinations are not based on the number of psychotropic drugs the foster child is taking).

tool.[61] They may even refuse to let a foster child attend school unless he or she begins taking medication for behavioral issues.[62] This problem became so pervasive that Congress addressed it in the 2004 Individuals with Disabilities Education Act Reauthorization (IDEA Reauthorization 2004). IDEA Reauthorization 2004 prohibits public school officials from "requiring a child to obtain a prescription for a substance covered by the Controlled Substances Act as a condition of attending school."[63] Covered substances include stimulants like Ritalin or Adderall.[64] However, teachers are not prohibited from "consulting or sharing classroom-based observations with parents or guardians regarding a student's . . . behavior in the classroom or school,"[65] leaving school personnel opportunities to pressure caretakers to administer psychotropic medication.

H. Conclusion

The fundamental challenge facing foster children is that the parties charged with making medical decisions for them are not always emotionally invested in them. Children entering foster care are more likely than other children to suffer from emotional and behavioral issues, whether because of neglect, abuse, or the trauma associated with removal from home. Foster parents, not paying as much attention to the dangers associated with psychotropic drugs as a biological parent would, look to doctors for help. Doctors, probably undertrained in child and adolescent psychiatry and influenced by the marketing techniques of the pharmaceutical industry, write prescriptions, sometimes for dangerous combinations of drugs. Dr. Euthymia Hibbs, chief of psychosocial treatment research for children and adolescents at the National Institutes of Health, neatly summarized the situation: "Putting kids on medication is easier for the people who care for them . . . . It is more convenient for everyone around—[except for] the kids."[66]

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61. *See* GABRIEL MYERS WORK GROUP, REPORT OF GABRIEL MYERS WORK GROUP 11 (2009), *available at* http://www.dcf.state.fl.us/initiatives/gmworkgroup/docs/GabrielMyersWorkGroupReport082009Final.pdf; Connie Lenz, *Prescribing a Legislative Response: Educators, Physicians, and Psychotropic Medication for Children*, 22 J. CONTEMP. HEALTH L. & POL'Y 72, 84 (2005).

62. LESLIE ET AL., MULTI-STATE STUDY, *supra* note 57.

63. 20 U.S.C. § 1412(a)(25)(A) (2006).

64. BOB JACOBS, LEGAL STRATEGIES TO CHALLENGE CHEMICAL RESTRAINT OF CHILDREN IN FOSTER CARE 7 (2006), *available at* http://www.guardianadlitem.org/documents/LegalStrategiestoChallengeChemicalRestraintofChildreninFosterCare.pdf.

65. 20 U.S.C. § 1412(a)(25)(B).

66. Weber, *supra* note 21.

II.
PRESSURES AGAINST MEDICATING

There are pressures against the overmedication of foster children, including negative media attention and class actions. Critics of a national legislative solution to foster care's psychotropics problem might argue that the media and class actions can adequately address the issue on the state level: where abusive prescription practices are particularly egregious, the local media will draw attention to the problem and child advocacy groups will file lawsuits, spurring the necessary reforms. However, negative media attention and class actions are not capable of producing permanent changes everywhere they are required, suggesting a need for federal legislative action.

A. Negative Media Attention

The ill-advised use of psychotropic drugs in foster care occasionally comes to the attention of the media. The death of Gabriel Myers, for example, touched off a media firestorm in Florida in 2009.[67] Myers was a seven-year-old foster child who hanged himself while taking several psychotropic drugs whose side effects included increased risk of suicide.[68] The uproar led to the formation of a task force to study what went wrong in Myers' case and to make recommendations for statewide reform.[69] A bill was introduced in the Florida Senate that would have tightened restrictions on the psychotropic drugs administered to foster children age ten or younger.[70] The bill survived committee review in the Senate but failed to garner enough support to make it through Florida's House of Representatives.[71]

Incidents like Myers' suicide illustrate why the media cannot be an effective agent of change on the psychotropic drug issue. First, the media only pays attention after a terrible tragedy occurs.[72] My-

67. Edecio Martinez, *After 7-Year-Old Gabriel Myers' Suicide, Fla. Bill Looks to Tighten Access to Psychiatric Drugs*, CBS NEWS (Mar. 17, 2010, 6:17 AM), http://www.cbsnews.com/news/after-7-year-old-gabriel-myers-suicide-fla-bill-looks-to-tighten-access-to-psychiatric-drugs/.

68. GABRIEL MYERS WORK GROUP, *supra* note 61, at 3.

69. Martinez, *supra* note 67.

70. *Id.*

71. Dara Kam, *House Won't Make It Harder for State to Put Foster Kids on Psych Drugs*, PALM BEACH POST ON POLITICS BLOG (Feb. 9, 2012, 6:30 PM), http://postonpolitics.blog.palmbeachpost.com/2012/02/09/house-wont-make-it-harder-for-state-to-put-foster-kids-on-psych-drugs/.

72. *See* Camp, *supra* note 60, at 374 (arguing that "growing media coverage of high profile cases involving children in foster care receiving psychotropic medica-

ers' caretakers were inappropriately administering psychotropic medication for years before he took his own life, but this was not deemed worthy of media coverage.[73] Second, media attention can prompt policymakers to begin thinking about reform, but it cannot ensure that they will follow through after the spotlight is gone. In Myers' case, the initial burst of media coverage caused Florida politicians to introduce a bill addressing the medication problem, but it was not enough to secure the bill's passage in the legislature.[74] While the media can be a good resource for drawing attention to the psychotropic drug problem, it is not capable of solving the problem.

B. Class Actions

Class actions have shown some potential as a tool to address the psychotropic drug crisis. If a state's foster care system has deep structural flaws that are hurting the children in its custody, an advocacy group may file a lawsuit on the children's behalf seeking reform. For example, the national advocacy group Children's Rights filed suit against Tennessee in 2000.[75] The complaint alleged, among other things, that the state was inappropriately medicating foster children with psychotropic drugs.[76] The settlement that was eventually reached mandated the appointment of a medical director to oversee the administration of psychotropic medication to children in state custody.[77] In the years since the settlement, Tennessee has developed a stringent review system that has produced measurable reductions in the number of foster children taking psychotropic drugs.[78] Individuals involved in the system's creation

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tions at extremely young ages, at extremely high rates, or with devastating results" has prompted reform); Crary, *supra* note 20 (observing that states take action on psychotropic drugs in response to "overdose tragedies" or "damning investigations").

73. GABRIEL MYERS WORK GROUP, *supra* note 61, at 4.

74. Kam, *supra* note 71.

75. Complaint, Brian A. *ex rel.* Brooks v. Sundquist, 149 F. Supp. 2d 941 (M.D. Tenn. 2000) (No. 300-0445), *available at* http://www.childrensrights.org/wp-content/uploads/2008/06/2000-05-10_tn_briana_complaint.pdf; *Tennessee (Brian A. v. Haslam)*, CHILDREN'S RIGHTS, http://www.childrensrights.org/reform-campaigns/legal-cases/tennessee/ (last visited Jan. 14, 2014).

76. Complaint, *supra* note 75, at 35.

77. CHILDREN'S RIGHTS, INC., TENNESSEE FACT SHEET 7 (2009), *available at* http://www.childrensrights.org/wp-content/uploads//2010/02/2009-11-13_tn_brian_a_fact_sheet_final.pdf.

78. *See infra* Part IV.C.

have credited the Children's Rights lawsuit with spurring the needed reforms.[79]

Nevertheless, class actions are limited in their ability to produce change. Advocacy groups typically only show interest in bringing suits where problems are particularly egregious. In Tennessee, for instance, Children's Rights was moved to pursue the psychotropic drug issue in part because of an incident in which a foster child almost threw himself off a roof during a medication-induced hallucination.[80] Addressing only the extremely shocking incidents of psychotropic drug misuse leaves unprotected those foster children experiencing more routine, but no less real, abuses.

III.
EXTENT OF THE CURRENT CRISIS

Consistent with the previous analysis, the available evidence suggests that the pressure to medicate foster children vastly outweighs the pressure against medicating. The statistics are sufficiently alarming that they have inspired both private and public attempts to remedy the situation.

A. Statistics

Several states have commissioned studies to better understand the extent of the psychotropic medication crisis. Florida,[81] Tennessee,[82] and North Carolina[83] all found that about a quarter of children in foster care were taking at least one psychotropic drug. In Georgia, 32.5% of foster children had a prescription for a psychotropic,[84] as did 35% of children in Utah.[85] Texas discovered that 37.9% of its foster children were on psychotropic medication,[86]

79. *2008 Hearing*, *supra* note 46, at 22 (statement of Tricia Lea, Director of Medical & Behavioral Services, Tennessee Department of Children's Services).

80. Complaint, *supra* note 75, at 35.

81. Carol Marbin Miller, *1 in 4 Foster Kids on Risky Mind Medication*, MIAMI HERALD, Jan. 15, 2005, at 1A.

82. Bellonci & Henwood, *supra* note 8, at 33.

83. Kevin Kelley et al., *Monitoring and Oversight of Psychotropic Medications for Children in Foster Care in North Carolina*, FAMILY & CHILDREN'S RESOURCE PROGRAM 14 (Jan. 29, 2013), http://fcrp.unc.edu/pdfs/psychotropicmeds_webinar.pdf.

84. CARTER, *supra* note 8, at 12.

85. Julie S. Steele & Karen F. Buchi, *Medical and Mental Health of Children Entering the Utah Foster Care System*, 122 PEDIATRICS 703, 703 (2008).

86. Julie M. Zito et al., *Psychotropic Medication Patterns Among Youth in Foster Care*, 121 PEDIATRICS 157, 158 (2008).

while the figure in Iowa was 42%.[87] Maryland, Delaware, California, and Pennsylvania have also reported high rates of psychotropic drug use in their foster care populations.[88]

The numbers also revealed that many foster children were concurrently prescribed more than one medication. More than 6% of North Carolina foster children were prescribed two psychotropics and almost 9% were prescribed three or more.[89] One in ten Florida foster children were taking three drugs simultaneously.[90] Among Texas foster children receiving psychotropic medication, 41% received three or more different classes of drugs and almost 16% received four or more different classes.[91] Among Utah foster children prescribed a psychotropic, 42% were prescribed more than two medications.[92] Almost 5% of Georgia foster children taking psychotropics received at least four different drugs.[93]

The statistics are dramatically worse when compared to the numbers for children outside the foster care system. Most studies identify the rates of psychotropic medication use in state foster care populations at between 13% and 37%, as compared to 4% for children in the general population.[94] One study estimated that children in foster care are sixteen times more likely to receive a prescription for a psychotropic drug than are non-foster children.[95]

Skeptics question the value of comparing children in foster care to children in the general population, theorizing that the higher medication rates can be explained through the greater prevalence of mental illness and behavioral problems in the foster care population.[96] However, studies comparing children enrolled in

87. PUB. POLICY CTR., UNIV. OF IOWA, HEALTH POLICY BRIEF: A STUDY OF IOWA'S CHILDREN IN FOSTER CARE 3 (2004), *available at* http://ir.uiowa.edu/cgi/viewcontent.cgi?article=1003&context=ppc_health.

88. *2008 Hearing*, *supra* note 46, at 9 (statement of Julie M. Zito, Professor of Pharmacy & Psychiatry, Pharmaceutical Health Services Research, University of Maryland).

89. Kelley et al., *supra* note 83.

90. Miller, *supra* note 81.

91. Zito et al., *supra* note 86, at 157.

92. Chris Chytraus & Navina Forsythe, *Psychotherapeutic Medication Report on Utah's Foster Care Clients*, 15 UTAH'S HEALTH: AN ANN. REV. 21, 21 (2010).

93. CARTER, *supra* note 8, at 12.

94. Lisa Hunter Romanelli et al., *Best Practices for Mental Health in Child Welfare: Screening, Assessment, and Treatment Guidelines*, 88 CHILD WELFARE 163, 184 (2009).

95. Sparks & Duncan, *supra* note 44, at 25.

96. *See, e.g.*, ADMIN. FOR CHILDREN & FAMILIES, U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 18, at 5 ("Although numerous studies have demonstrated that the rates of psychotropic medication prescriptions are high among children in foster care, these rates, at least in part, may reflect increased levels of

Medicaid show there is still cause for concern. There are three categories of children eligible for Medicaid: those who receive Temporary Assistance for Needy Families (TANF), those who receive Supplemental Security Income because of physical or mental disabilities (SSI/disability), and those who are in foster care.[97] A study working with 2005 Medicaid data from all fifty states concluded that foster children constituted about 3% of the Medicaid child population but almost 13% of the children taking psychotropic drugs.[98] Twenty-three percent of foster children, compared to 27% of SSI/disability children and 4% of TANF children, were on psychotropic medication.[99] Of those foster children being treated with psychotropic drugs, 42% were prescribed antipsychotics, compared to 42% of SSI/disability children and 18% of TANF children.[100] Almost half (48.7%) of foster children taking psychotropic drugs received two or more concurrent prescriptions, compared to 46.4% of SSI/disability children and 25.8% of TANF children.[101]

A Government Accountability Office study using 2008 Medicaid data from Florida, Massachusetts, Michigan, Oregon, and Texas found similar patterns. Foster children were 2.7 to 4.5 times more likely to be prescribed a psychotropic drug than their non-foster counterparts.[102] Foster children were also nine times more likely than other Medicaid-eligible children to be prescribed psychotropic drugs on an off-label basis.[103] In addition, foster children were at greater risk of taking multiple psychotropic drugs at one time.[104] The state with the greatest disparity was Texas, where children in care were fifty-three times more likely than non-foster children to be taking five or more psychotropic drugs simultaneously, followed by Massachusetts (nineteen times), Michigan (fifteen times), Oregon (thirteen times), and Florida (four times).[105]

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emotional and behavioral distress."); CTR. FOR MEDICARE & MEDICAID SERVS., U.S. DEP'T OF HEALTH & HUMAN SERVS., TRI-AGENCY LETTER ON APPROPRIATE USE OF PSYCHOTROPIC MEDICATIONS AMONG CHILDREN IN FOSTER CARE (Nov. 23, 2011), *available at* http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-11-23-11.pdf ("Research has clearly demonstrated that children known to the child welfare system are diagnosed with mental health disorders at a much higher rate than the general population.").

97. PIRES ET AL., *supra* note 11, at 8.
98. *Id.* at 62–63.
99. *Id.* at 61.
100. *Id.* at 67.
101. *Id.* at 66.
102. *2011 Hearing*, *supra* note 24, at 60.
103. Abdelmalek et al., *supra* note 9.
104. *Id.*
105. *Id.*

Taken together, these studies indicate that foster children are uniquely vulnerable to overmedication with psychotropic drugs. Children in foster care are medicated at roughly the same rate as disabled children, many of whom have disorders for which psychotropic drugs are an FDA-approved treatment.[106] They are as likely as disabled children to receive antipsychotics, one of the most dangerous classes of psychotropic medications.[107] And they are the most likely of all Medicaid-eligible children to be prescribed potentially risky combinations of drugs.

B. National Responses

Professional associations have participated in initiatives designed to help prescribing physicians understand the dangers posed by psychotropics. In 2013, the American Psychiatric Association (APA), the largest professional organization of psychiatrists in the United States, joined the Choosing Wisely campaign.[108] The Choosing Wisely campaign aims to reduce the number of psychotropic prescriptions written for children by issuing guidelines on appropriate use.[109] Its recommendations include avoiding the use of antipsychotics as a first-line treatment for conditions other than psychotic disorders, and, if antipsychotics must be prescribed, not prescribing two or more concurrently.[110]

Several states have attempted to address the underlying causes of the psychotropic drug crisis. The Colorado and Texas Boards of

106. For example, the FDA approved Risperdal, an atypical antipsychotic, to treat the irritability associated with autism in children and adolescents. Press Release, FDA, FDA Approves the First Drug to Treat Irritability Associated with Autism, Risperdal (Oct. 6, 2006), *available at* http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/2006/ucm108759.htm; *see also Atypical Antipsychotic Drugs Information*, U.S. Food & Drug Admin., http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm094303.htm (last visited Oct. 6, 2014) (describing Risperdal as an atypical antipsychotic).

107. *See supra* notes 11–12 and accompanying text.

108. Kim Painter, *Doctors: Anti-Psychotic Meds Overused for Dementia, Kids*, USA Today (Sept. 23, 2013), http://www.usatoday.com/story/news/nation/2013/09/21/antipsychotic-dementia-children/2844419/; *About APA & Psychiatry*, Am. Psychiatric Ass'n, http://www.psychiatry.org/about-apa—psychiatry (last visited Oct. 6, 2014) (describing the APA as "the world's largest psychiatric organization").

109. *About Us*, Choosing Wisely, http://www.choosingwisely.org/doctor-patient-lists/american-psychiatric-association/ (last visited Oct. 29, 2014); *see also* Painter, *supra* note 108.

110. *Five Things Physicians and Patients Should Question: American Psychiatric Association*, Choosing Wisely, http://www.choosingwisely.org/doctor-patient-lists/american-psychiatric-association/ (last visited Jan. 14, 2014).

Education both passed resolutions calling on school personnel to use traditional classroom management techniques in lieu of psychotropic medication to control disruptive behaviors.[111] A Virginia law prohibits school officials from recommending that students begin taking psychotropic drugs.[112] The Hawaii legislature passed a resolution instructing the state to consider nonpharmaceutical alternatives for children in foster care taking psychotropic drugs.[113] Washington and North Carolina enacted laws requiring the state to monitor the number of children in foster care being treated with a psychotropic.[114] California authorized state agencies to adopt regulations governing the administration of psychotropic medication to children in care.[115] A recent Oregon law requires a mental health assessment prior to the prescription of an antipsychotic as well as annual case reviews for children taking more than two psychotropic drugs concurrently.[116]

The federal government has also turned its attention to the issue. The House Ways and Means Committee held one hearing on Health Care for Children in Foster Care in 2007 and another on Prescription Psychotropic Drug Use among Children in Foster Care in 2008, while the Senate's Committee on Homeland Security and Governmental Affairs held a hearing on the Financial and Societal Costs of Medicating America's Foster Children in 2011.[117] At all three hearings, expert witnesses testified to the seriousness of the psychotropic drug crisis, described how different states were handling the problem, and proposed their own solutions.[118] Several members of Congress expressed willingness to pursue a federal response to the issue.[119]

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111. DARCY E. GRUTTADARO & JOEL E. MILLER, CHILDREN AND PSYCHOTROPIC MEDICATIONS 8–9 (2004), *available at* http://www.nami.org/Template.cfm?Section=other&Template=/ContentManagement/ContentDisplay.cfm&ContentID=15860.

112. *Id.* at 9.

113. *Id.*

114. *Id.*

115. *Id.*

116. RUTGERS STUDY, *supra* note 8, at 44–45.

117. *2011 Hearing*, *supra* note 24; *2008 Hearing*, *supra* note 46; *Health Care for Children in Foster Care: Hearing Before the Subcomm. on Income Sec. & Family Support of the H. Comm. on Ways & Means*, 110th Cong. (2007) [hereinafter *2007 Hearing*].

118. *2011 Hearing*, *supra* note 24, at 18, 20, 22, 24, 28–29, 100–01, 129, 137, 142, 148–50, 154, 156, 182; *2008 Hearing*, *supra* note 46, at 8–10, 16–17, 20–25, 58–59, 61–63, 71, 87; *2007 Hearing*, *supra* note 117, at 26–30.

119. *See 2011 Hearing*, *supra* note 24, at 31 (statement of Sen. Brown, Member, S. Comm. on Homeland Security & Governmental Affairs) ("[H]ow does this happen and who is responsible and how do we fix it?"); *2008 Hearing*, *supra* note

The solution Congress devised was embedded in the Child and Family Services Improvement and Innovation Act of 2011. The Act requires states to establish "protocols for the appropriate use and monitoring of psychotropic medications" before they may receive federal child welfare funds.[120] State protocols are evaluated on five criteria: (1) screening, assessment, and treatment planning for foster children's unique mental health needs; (2) mechanisms for obtaining informed consent before medication use; (3) systems for monitoring medication use at both child and population levels; (4) availability of a board-certified or board-eligible child and adolescent psychiatrist to consult on both consent and monitoring issues; and (5) access to and dissemination of the latest information on mental health and trauma-related interventions.[121]

The Child and Family Services Improvement and Innovation Act is an admirable first step toward reform, as it at least acknowledges that there is a serious psychotropic drug problem in the nation's foster care system. But it does not go far enough to protect foster children from the risk of overmedication. Because the law merely establishes criteria on which state protocols are evaluated and does not mandate the adoption of specific protocols, there is room for significant variation among states.[122] In addition, because states can fail to meet one or more of the criteria without losing federal funding, no state has established protocols satisfying all five standards.[123]

The second half of this Note will argue for a stronger federal role in addressing foster care's psychotropic drug problem. Part IV will analyze the psychotropic medication protocols in place in five states: Illinois, Florida, Tennessee, Massachusetts, and Connecticut. Parts V and VI will advocate for the nationwide implementation of a system of child welfare agency consent and red flag preconsent re-

46, at 3 (statement of Rep. McDermott, Member, H. Comm. on Ways & Means) (arguing that the federal government has "a special obligation . . . to protect and care for [foster children]").

120. Child and Family Services Improvement and Innovation Act, Pub. L. No. 112-34, § 101(b)(2), 125 Stat. 369, 369 (2011) (codified as amended in scattered sections of 42 U.S.C.).

121. Office of Planning, Research & Evaluation, U.S. Dep't of Health & Human Servs., Rep. No. 2012-33, Psychotropic Medication Use by Children in Child Welfare 7 (2012), *available at* http://www.acf.hhs.gov/sites/default/files/opre/psych_med.pdf; Eva J. Klain, *Improving Oversight of Psychotropic Medication Use with Children in Foster Care*, 31 Child. L. Prac. 109 (2012).

122. *2011 Hearing*, *supra* note 24, at 7 (statement of Sen. Collins, Member, S. Comm. on Homeland Security & Governmental Affairs).

123. *Id.*

view. The final Part will recommend that the federal government encourage reform by tying the availability of federal funds to state use of red flag preconsent reviews.

IV.
STATE APPROACHES TO THE CRISIS

A handful of states have taken the lead in confronting the psychotropic drug crisis. Illinois, Florida, Tennessee, Massachusetts, and Connecticut have all adopted different approaches to the problem. The following sections will explore each state's system in depth and offer an evaluation of their respective efficacies.

A. Illinois

Illinois's Department of Children and Family Services (ILDCFS) was under attack throughout the 1990s. A 1991 class action alleged that the state's child welfare system was violating foster children's constitutional rights[124] and a 1995 series of pieces in the Chicago Tribune harshly criticized the agency's failures.[125] The enhanced scrutiny prompted the state to attempt reform, particularly of the ways medication is administered to the foster care population.[126]

ILDCFS promulgated a rule mandating that prescribing physicians obtain consent from ILDCFS prior to starting a foster child on a psychotropic medication.[127] The prescribing physician sends the ILDCFS Centralized Consent Unit (CCU) a request to start medication.[128] ILDCFS then forwards the request to the Clinical Services in Psychopharmacology Program at the University of Illinois at Chicago.[129] A board-certified child and adolescent psychiatrist evalu-

124. *See* Michael W. Naylor, *Psychiatric Consultation in a Psychotropic Medication Oversight Program for Foster Children: The Illinois Model*, PALTECH 3, http://www.paltech.com/web/psychotropic/documents/Workshop%206%20-%20Naylor.pptx (last visited Nov. 2, 2014).

125. R. Bruce Dold, Op-Ed., *Kids Suffer Under DCFS Reform Efforts*, CHI. TRIB., Sept. 22, 1995, http://articles.chicagotribune.com/1995-09-22/news/9509220377_1_consent-decree-child-welfare-aclu; Editorial, *A Vote for Jess McDonald*, CHI. TRIB., Oct. 20, 1995, http://articles.chicagotribune.com/1995-10-20/news/9510200016_1_child-welfare-system-child-abuse-problem-kids-in-state-care (labeling ILDCFS "the poster child for government indifference and inefficiency").

126. *See* Naylor, *supra* note 124, at 6–10.

127. ILL. ADMIN. CODE tit. 89, § 325.10 (2012).

128. *2007 Hearing*, *supra* note 117, at 30 (statement of Michael W. Naylor, Director, Division of Child & Adolescent Psychiatry, Program Institute for Juvenile Research, University of Illinois-Chicago).

129. *Id.*

ates the request in light of the clinical and demographic data provided and recommends approval, denial, or modification.[130] The psychiatrist's recommendation goes to the CCU, where an authorized agent makes a decision and notifies the prescribing physician.[131] The expected turnaround time is twenty-four hours for inpatient requests and forty-eight hours for all other requests.[132] A physician may prescribe medication without ILDCFS consent in an emergency, but the University of Illinois-Chicago, which maintains the consent database for ILDCFS, will subsequently review all such prescriptions.[133]

Each psychotropic medication request receives some scrutiny. Certain requests, however, will get a closer review, including those for four or more psychotropic medications prescribed concomitantly; for any psychotropic medication other than stimulants for children under age four; for two or more antidepressants, two or more antipsychotics, two or more stimulants, or three or more mood stabilizers prescribed concomitantly; for frequent changes of medications without a clear rationale; for prescriptions inconsistent with the patient's diagnosis; for multiple psychotropic drugs before one drug alone has been tried; for dosages exceeding those usually recommended; for psychostimulants for an actively psychotic child; and for emergency medications more than twice a day for three or more consecutive days.[134]

Physicians who violate ILDCFS rules face professional consequences. Each psychotropic medication started without ILDCFS consent generates notifications to the physician that he or she is in violation of ILDCFS Rule 325.[135] A physician who receives five such notifications gets a first warning letter informing him or her that ILDCFS may file a complaint with the Illinois Department of Financial and Professional Regulation upon further violations.[136] A second warning letter is sent after five additional violations, with the

130. *Id.*

131. *Id.*

132. ILL. ADMIN. CODE tit. 89, § 325.40(a).

133. Michael W. Naylor et al., *Psychotropic Medication Management for Youth in State Care: Consent, Oversight, and Policy Considerations*, 86 CHILD WELFARE 175, 186 (2007).

134. ILL. DEP'T OF CHILDREN & FAMILY SERVS., GUIDELINES FOR THE UTILIZATION OF PSYCHOTROPIC MEDICATIONS FOR CHILDREN IN FOSTER CARE 6–7 (2008), *available at* http://www.state.il.us/dcfs/docs/ocfp/rules/rules_325.pdf. The Illinois guidelines use "concomitantly" to mean "concurrently."

135. ILL. ADMIN. CODE tit. 89, § 325.80(a)(1).

136. *Id.* § 325.80(a)(2).

eleventh violation prompting the lodging of the threatened complaint.[137]

Illinois has used this system to detect dangerous prescription patterns and educate physicians on how to avoid them.[138] The state has also been able to identify and take corrective action against physicians who repeatedly prescribe outside the guidelines.[139] Experts in the field of child and adolescent psychiatry have praised the Illinois model for providing "patient-specific, individualized review[s]" that improve the safety of the psychotropic prescriptions written for children in care.[140]

B. Florida

Florida gives authority to consent to treatment with psychotropic medication to the foster child's birth parents.[141] If the parents cannot be located, refuse to consent, or have had their legal rights terminated, authorization to treat must be sought through court order.[142] An agent of the Department of Children and Families (FLDCF) must file a motion with the court supported by a medical report containing: the name and dosage of the psychotropic drug; the diagnosis the drug was prescribed to treat; the recognized side effects of the drug; a plan for monitoring the treatment; the amount of time the child is expected to be on the drug; and a statement confirming that the information in the report was explained to the child and the child's caretaker.[143]

Under certain circumstances, a child and adolescent psychiatrist must review the proposed treatment before a parent or judge can consent: preconsent review is necessary before the prescription of two or more psychotropic drugs to any foster child under age

137. *Id.* § 325.80(a)(3)–(4).

138. *2007 Hearing*, *supra* note 117, at 27 (statement of Michael W. Naylor, Director, Division of Child & Adolescent Psychiatry, Program Institute for Juvenile Research, University of Illinois-Chicago).

139. *Id.*

140. *2008 Hearing*, *supra* note 46, at 10 (statement of Julie M. Zito, Professor of Pharmacy & Psychiatry, Pharmaceutical Health Services Research, University of Maryland); *see also* LAUREL K. LESLIE ET AL., EXAMINATION OF THE *ROGERS* PROCESS FOR YOUTH IN THE CUSTODY OF THE MASSACHUSETTS DEPARTMENT OF CHILDREN AND FAMILIES 18 (2011) [hereinafter LESLIE ET AL., EXAMINATION OF THE *ROGERS* PROCESS], *available at* http://www.tuftsctsi.org/About-Us/News/Archive/~/media/522D7F0CCEAB4115B5D1365B70B0D96D.ashx (quoting a child and adolescent psychiatrist as stating that the Illinois model "works really well").

141. FLA. ADMIN. CODE ANN. r. 65C-35.007(1) (2010).

142. *Id.* r. 65C-35.007(2).

143. FLA. STAT. § 39.407(3)(c)(1)–(5) (2013).

eleven[144] unless a parent whose rights have not been terminated waives this requirement.[145] Under the preconsent review system, the child's caseworker and prescribing physician complete a Psychotropic Medication Report, which is then submitted to the Department of Psychiatry within the University of Florida College of Medicine.[146] A psychiatrist reviews the report for conformity with accepted medical practice, records his or her recommendations, and returns the report within one business day.[147] If the psychiatrist disagrees with the proposed course of treatment, he or she contacts the prescribing physician to discuss the child's case.[148] FLDCF sends the psychiatrist's recommendation to the party with legal authority to consent, who uses it to inform his or her final decision.[149] Medication may be prescribed without preconsent review when the prescribing physician certifies that delay would more likely than not cause significant harm to the child.[150]

In the wake of the Gabriel Myers tragedy,[151] the Florida Supreme Court's Steering Committee on Families and Children appointed a subcommittee charged with improving judicial oversight of the administration of psychotropic medication in the foster care system.[152] The subcommittee produced a Psychotropic Medications Judicial Reference Guide, explaining the purposes and side effects of popular psychotropic drugs, as well as a Psychotropic Medications Bench Card, clarifying the substantive and procedural implications of a psychotropic medication request.[153] The subcommittee's efforts are expected to better prepare judges to

144. *Pre-Consent Review for Psychotropic Medication*, COMMUNITY PARTNERSHIP FOR CHILDREN 2 (Feb. 4, 2011), http://www.communitypartnershipforchildren.org/zupload/user/policies/bhs585pre-consentreviewforpsychotropicmedicationtreatmentplans.pdf.

145. Memorandum from Alan Abramowitz, State Dir., Office of Family Safety, to Community-Based Care CEOs et al. (Dec. 2, 2010), *available at* http://centerforchildwelfare2.fmhi.usf.edu/kb/policymemos/New%20requirements%20for%20pre_consent%20review%20of%20PsyMeds%20for%20children%20in%20OHC_final%20signed.pdf.

146. *Pre-Consent Review for Psychotropic Medication*, *supra* note 144, at 3.

147. *Id.*

148. *Id.*

149. *Id.*

150. FLA. ADMIN. CODE ANN. r. 65C-35.010(1)(a) (2010).

151. Martinez, *supra* note 67.

152. FLA. DEP'T OF CHILDREN & FAMILIES, PSYCHOTROPIC MEDICATION: A REVIEW OF ACTIONS TAKEN TO IMPLEMENT RECOMMENDATIONS FROM THE GABRIEL MYERS WORKGROUP 10–11 (2010), *available at* http://www.dcf.state.fl.us/initiatives/childsafety/meetings/Task%20force%20on%20Fostering%20Success%20.pdf.

153. *Id.* at 12.

handle their role as medical consenters for some children in foster care.[154]

It is unclear whether Florida's approach has reduced the number of unnecessary or dangerous psychotropic prescriptions issued to foster children (the efficacy of systems that rely on judicial oversight is discussed in more general terms in Part V.C). Florida has, however, reduced the number of prescriptions issued without proper authorization. At the time of Gabriel Myers's suicide, 35% of Florida foster children were taking psychotropic medication without consent.[155] In the immediate aftermath of the tragedy, the state reduced that number to 6.45%.[156] By mid-2013, only 0.5% of foster children were being medicated without consent.[157]

C. Tennessee

After the advocacy group Children's Rights filed a class action alleging inappropriate use of psychotropics in its foster care system, Tennessee turned its attention to psychotropic drug use in the foster care population.[158] In consultation with expert consultants from the Child Welfare League of America (CWLA), the state revised its psychotropic medication policies.[159] State law gives authority to consent to psychotropic drug treatment to a foster child's birth parents unless the child is sixteen years of age or older or parental rights have been terminated.[160] If the child is sixteen or older, he or she is empowered to give or withhold consent to treatment.[161] If the child is younger than sixteen and his or her biological parents' rights have been terminated, authority to consent goes to one of the twelve Department of Children's Services (DCS) Regional Nurses.[162]

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154. *See id.* at 13.

155. *Id.* at 14.

156. *Id.*

157. *Id.*

158. *See supra* Part II.B; *see also 2008 Hearing*, *supra* note 46, at 22 (statement of Tricia Lea, Director of Medical & Behavioral Services, Tennessee Department of Children's Services); Bellonci & Henwood, *supra* note 8, at 30.

159. Bellonci & Henwood, *supra* note 8, at 32.

160. TENN. DEP'T OF CHILDREN'S SERVS., ADMINISTRATIVE POLICIES AND PROCEDURES 20.24 (Aug. 2011), *available at* http://www.tn.gov/youth/dcsguide/policies/chap20/20.24.pdf.

161. *Id.* at 3.

162. *Id.* at 5–6.

DCS gives particular scrutiny to requests for pro re nata (PRN), or "use as needed," prescriptions.[163] PRN prescriptions for anxiolytic-hypnotic drugs (used to treat insomnia and anxiety disorders) and PRN antipsychotic prescriptions require prior approval from DCS.[164] The prescribing physician must submit a form to a DCS Regional Nurse describing the condition or symptoms the PRN psychotropic medication is supposed to treat; any other behavioral interventions being used; all other medications the child is taking; the time period for which the medication will be used; and the anticipated frequency of use.[165] The DCS Regional Nurse reviews the form then sends it to the DCS Central Office for approval by the DCS Chief Medical Officer.[166]

For all other types of psychotropic prescriptions, DCS uses a dual system of review. When consent is obtained from a youth age sixteen or older or from the youth's birth parents, no DCS action is required before the prescription can be filled.[167] The DCS Regional Nurse is notified of such a prescription and enters the information into the DCS electronic record.[168] Any prescription that falls outside the state's psychotropic medication utilization parameters generates an alert to the DCS Chief Medical Officer,[169] who may order a review of the child's case.[170]

When consent must be obtained from the DCS Regional Nurse, preconsent review is required for certain types of prescriptions. Prescriptions to children age five and under must be approved by a child and adolescent psychiatrist in the DCS Central Office.[171] Prescriptions to children between ages six and ten must be approved by both a nurse practitioner and a psychologist or psy-

163. TENN. DEP'T OF CHILDREN'S SERVS., ADMINISTRATIVE POLICIES AND PROCEDURES 20.18 (Aug. 2011), *available at* http://www.tn.gov/youth/dcsguide/policies/chap20/20.18.pdf.

164. *Id.* at 4.

165. *Id.* at 4–5.

166. *Id.* at 5.

167. WORTHINGTON, *supra* note 31, at 27.

168. TENN. DEP'T OF CHILDREN'S SERVS., ADMINISTRATIVE POLICIES AND PROCEDURES 20.18, *supra* note 163.

169. *See* TENN. DEP'T OF CHILDREN'S SERVS., ADMINISTRATIVE POLICIES AND PROCEDURES 20.18, *supra* note 163 (stating that cases falling outside the parameters "are assessed by DCS Regional Nurses, the DCS Chief Medical Officer, or designee"); WORTHINGTON, *supra* note 31, at 30 ("When a prescription falls outside the psychotropic medication utilization parameters, automatic alerts are sent to the agency medical directors.").

170. TENN. DEP'T OF CHILDREN'S SERVS., ADMINISTRATIVE POLICIES AND PROCEDURES 20.18, *supra* note 163.

171. Naylor et al., *supra* note 133, at 182–83.

chiatrist in the central office.[172] In deciding whether to grant approval, DCS can seek advice from any of the Centers of Excellence housed at universities across the state.[173] The Centers of Excellence evaluate particularly complicated cases, as where a child has multiple diagnoses or a history of disrupted placements.[174] There is no emergency exception to the preconsent review requirement unless the child is in a hospital or a Psychiatric Residential Treatment Facility.[175]

Tennessee's approach has been lauded as a creative effort to discourage dangerous prescription practices.[176] The state has also been able to report specific instances of improvement. One fourteen-year-old child was living in a residential treatment facility and receiving six psychotropic drugs concurrently.[177] The medication combination fell outside the utilization parameters, prompting a referral to one of the Centers of Excellence.[178] The child was subsequently taken off several medications and transitioned to a family foster home.[179] The reforms are also credited with producing a drop in the percentage of foster children taking a psychotropic drug, from 25% in 2004 to 21% in 2006.[180]

D. Massachusetts

The Massachusetts model dates back to a 1983 Supreme Judicial Court decision. In *Rogers v. Commissioner of the Department of Mental Health*,[181] the court was asked to determine whether the administration of antipsychotic medications to an individual who is incompetent to give informed consent requires prior judicial approval. Noting that antipsychotics may be abused "by those claiming to act in an incompetent's best interests," the court concluded that judicial approval must be sought before all nonemergency adminis-

172. *Id.* at 183.

173. *Id.*

174. Bellonci & Henwood, *supra* note 8, at 41.

175. TENN. DEP'T OF CHILDREN'S SERVS., ADMINISTRATIVE POLICIES AND PROCEDURES 20.18, *supra* note 163.

176. *2008 Hearing*, *supra* note 46, at 10 (statement of Julie M. Zito, Professor of Pharmacy & Psychiatry, Pharmaceutical Health Services Research, University of Maryland).

177. *Id.* at 21 (statement of Tricia Lea, Director of Medical & Behavioral Services, Tennessee Department of Children's Services).

178. *Id.*

179. *Id.*

180. *Id.* at 24.

181. 458 N.E.2d 308, 310 (Mass. 1983).

trations of antipsychotics to incompetent patients.[182] The decision was subsequently incorporated into Department of Children and Families (MADCF) regulations.[183]

Current MADCF regulations distinguish between routine and extraordinary medical care.[184] For routine medical care, including treatment with non-antipsychotic psychotropic medication,[185] MADCF social workers are authorized to consent on the foster child's behalf.[186] For extraordinary medical care, including the use of antipsychotic drugs, MADCF must seek court approval.[187] Court approval is unnecessary in an emergency, when a physician determines that medication is required to prevent "the immediate, substantial, and irreversible deterioration of a serious mental illness."[188]

Once MADCF learns that a physician plans to prescribe an antipsychotic for a foster child, the agency submits a *Rogers* Petition asking the court to appoint a guardian ad litem (GAL).[189] The GAL conducts an investigation into the appropriateness of the proposed medication regimen, gathering information from medical records, the prescribing physician, the child, the child's caseworker and caregivers, and other interested parties.[190] The GAL then submits a report containing his or her recommendations to the court.[191] The prescribing physician must also submit an affidavit disclosing the risks and benefits of the proposed treatment, the child's prognosis with and without treatment, and the child's expressed preferences.[192] The judge then holds a hearing to consider the GAL's

182. *Id.* at 320–22 (quoting *In re* Guardianship of Roe, 421 N.E.2d 40, 53 n.11 (Mass. 1981)).

183. *Revisiting the* Rogers *Process for Children in State Custody: Is It Working?*, MASS. OFFICE OF THE CHILD ADVOCATE, http://www.mass.gov/childadvocate/examination-of-the-rogers-process.html (last visited Apr. 21, 2014).

184. 110 MASS. CODE REGS. 11.01 (2008).

185. *Id.* 11.04(1)(r).

186. *Id.* 11.04(2).

187. *Id.* 11.14(2).

188. *Id.* 11.14(6)(a)–(b).

189. Soc. Justice Program, Ne. Univ. Sch. of Law, *Court-Ordered Consent: Revisiting the Rogers Process for Children in State Custody*, MASS. OFFICE OF THE CHILD ADVOCATE 4 (Apr. 7, 2011), http://www.mass.gov/childadvocate/docs/nusl-full-report.pdf.

190. LESLIE ET AL., EXAMINATION OF THE *ROGERS* PROCESS, *supra* note 140, at 4.

191. *Id.*

192. *Clinician's Affidavit and Report for Extension and/or Amendment of Substituted Judgment Treatment Plan*, THE MASSACHUSETTS COURT SYSTEM, http://www.mass.gov/courts/docs/forms/probate-and-family/mpc823-clinicians-affidavit-sub-judgment-fill.pdf (last visited Jan. 14, 2014).

report and the prescriber's affidavit as well as statements from the child or biological parents.[193] If the request is approved, the judge issues a *Rogers* Order authorizing administration of the antipsychotic.[194]

In 2010, Massachusetts funded a study that used interviews with key stakeholders to evaluate the *Rogers* process.[195] Reviews of the system were decidedly mixed. Some stakeholders appreciated the role of the GAL, claiming that GALs could access information unavailable to other participants in the child welfare system and thereby make sound recommendations.[196] However, the GALs themselves—typically attorneys—sometimes reported that their lack of medical training made them "feel [un]comfortable questioning a good psychiatrist," casting doubt on their effectiveness as independent advocates for children's best interests.[197] There were also disagreements over whether the process reduced unnecessary prescriptions or denied access to needed medication. Child welfare professionals reported dealing with psychiatrists who initially insisted an antipsychotic was necessary then "suddenly change[d] their minds . . . when they learn[ed] that a *Rogers* Order [was] required."[198] Legal professionals argued that this means doctors are "really think[ing] about [the] medication[s] they're giving kids,"[199] while medical professionals viewed this as proof that the system is a "barrier to treatment."[200] One thing that all major stakeholders could agree on was that the *Rogers* process can take a long time: most respondents reported waiting weeks or months for *Rogers* Orders.[201]

Critics also questioned the need to single out antipsychotic drugs for special scrutiny.[202] The *Rogers* decision came before the introduction of atypical antipsychotics, which are considered less dangerous than the earlier generation of typical antipsychotics.[203]

193. Soc. Justice Program, Ne. Univ. Sch. of Law, *supra* note 189.

194. LESLIE ET AL., EXAMINATION OF THE *ROGERS* PROCESS, *supra* note 140, at 3.

195. *Revisiting the* Rogers *Process for Children in State Custody: Is It Working?*, *supra* note 183.

196. LESLIE ET AL., EXAMINATION OF THE *ROGERS* PROCESS, *supra* note 140, at 8.

197. *Id.*, app. at 16, *available at* http://www.tuftsctsi.org/About-Us/News/Archive/~/media/DCE8D6512EE44CF5B03B039A6AF95884.ashx.

198. *Id.* at 6.

199. *Id.* at 14.

200. *Id.* at 11.

201. LESLIE ET AL., EXAMINATION OF THE *ROGERS* PROCESS, *supra* note 140, at 9.

202. Merritt, *supra* note 6, at 18.

203. *Id.* at 14–15.

While antipsychotic use in foster care is an issue of concern,[204] system participants also identified a need to extend oversight to cover additional classes of psychotropic medications, use in young children, off-label use, and polypharmacy.[205]

E. Connecticut

Inspired by the Illinois model, Connecticut began overhauling its psychotropic drug policies in 1999.[206] After the state legislature mandated that the Department of Children and Families (CTDCF) establish a "state-of-the-art medication management system for children and youth in [CTDCF] care and custody,"[207] CTDCF formed a Centralized Medication Consent Unit (CMCU).[208] The CMCU, headed by a Chief of Psychiatry and staffed by child psychiatrists, advanced practice registered nurses (APRN), and support personnel, is empowered to consent to all psychotropic medication requests for children who are in foster care due to abuse or neglect.[209]

Under this system, the prescribing physician completes a request form and sends it to the CMCU.[210] Either a child psychiatrist or an APRN approves, denies, or modifies the request.[211] The child psychiatrist must be the one to make the decision when the child is under five years of age, is taking more than five medications, has been prescribed a drug that is not on the CTDCF Approved Drug List, or has been prescribed a dosage exceeding CTDCF's Maxi-

204. *See supra* notes 11–12.

205. LESLIE ET AL., EXAMINATION OF THE *ROGERS* PROCESS, *supra* note 140, at 15.

206. Lesley Siegel, *Consent for Psychotropic Medication: Connecticut's Model for Children and Youth in Foster Care*, PALTECH 4, http://www.pal-tech.com/web/psychotropic/documents/Workshop%203%20-%20Siegel.pptx (last visited Nov. 2, 2014).

207. CONN. DEP'T OF CHILDREN & FAMILIES, GUIDELINES FOR PSYCHOTROPIC MEDICATION USE IN CHILDREN AND ADOLESCENTS 8 (2010) [hereinafter CONN. DEP'T OF CHILDREN & FAMILIES, GUIDELINES], *available at* http://www.ct.gov/dcf/lib/dcf/behavorial_health_medicine/pdf/guidelines_psychotropic_medication.pdf.

208. Margaret Rudin & Lesley Siegel, *Psychotropic Medications and Foster Children*, PALTECH 26–28, https://www.pal-tech.com/intranet/OCAN/3393_Rudin,_M.-Psychotropic_Medication_Use_with_Children.pdf (last visited Nov. 2, 2014).

209. Children who have been voluntarily placed in foster care require consent from a biological parent to begin treatment. CONN. DEP'T OF CHILDREN & FAMILIES, POLICY 44-5-2.1, STANDARDS REGARDING THE DELIVERY OF HEALTH CARE (2011) [hereinafter CONN. DEP'T OF CHILDREN & FAMILIES, POLICY 44-5-2.1], *available at* http://www.ct.gov/dcf/cwp/view.asp?a=2639&Q=480666&PM=1.

210. *Id.*

211. *Id.*

mum Dosing Guidelines.[212] A request is more likely to be approved if the request form is "relatively complete," the medication fits the diagnosis, the child is not already on multiple psychotropic drugs, and the child has not been prescribed more than one antipsychotic.[213] Other factors that influence the decision include the child's setting, his or her history with the prescribing physician, other ongoing treatment, and the ultimate goal of the drug regimen.[214]

The CMCU processes urgent requests within twelve hours and routine requests within twenty-four hours.[215] The prescribing physician may appeal a CMCU denial to the Agency Medical Director, whose decision is final.[216] Medication may be administered without CMCU consent when the prescribing physician believes treatment is immediately necessary to prevent serious harm to the child, but the CMCU must be informed of emergency uses within three days.[217]

Outright denials of medication requests are rare,[218] but the CMCU has not operated as a mere rubber stamp. The number of approved requests declined from 84% in the first quarter of 2010 to 58% in the second quarter of 2012.[219] The difference is attributable to an increase in the number of requests modified by the CMCU, from 3% in the first quarter of 2010 to 29% in the second quarter of 2012.[220] Child and adolescent psychiatrists have praised Connecticut's system for its simple and efficient approach to protecting foster children.[221]

F. Conclusion

Each state's approach has strengths and weaknesses that make it more or less suitable for nationwide imposition. Illinois is to be commended for having a psychiatrist review every psychotropic prescription, but its relationship with the Clinical Services in

212. Rudin & Siegel, *supra* note 208, at 43.

213. Siegel, *supra* note 206, at 12–13.

214. *Id.* at 14.

215. Conn. Dep't of Children & Families, Guidelines, *supra* note 207, at 13.

216. Conn. Dep't of Children & Families, Policy 44-5-2.1, *supra* note 209.

217. Conn. Dep't of Children & Families, Form DCF-465, Psychotropic Medication Consent Request (2014), *available at* www.ct.gov/dcf/lib/dcf/policy/forms/dcf_465-ipr.doc.

218. 3% of requests are denied. Siegel, *supra* note 206, at 16.

219. *Id.*

220. *Id.*

221. *See, e.g.*, Leslie et al., Examination of the *Rogers* Process, *supra* note 140, at 17.

Psychopharmacology Program at the University of Illinois at Chicago may not be replicable across the country. Florida focuses its reviews on prescriptions perceived to be especially dangerous, but leaves consent in the hands of parties unsuited to resist pressures to medicate.[222] Tennessee protects children ages ten and under whose biological parents' rights have been terminated, but leaves other foster children vulnerable. Massachusetts forces doctors to carefully consider whether or not to prescribe an antipsychotic, but fails to curb the excessive use of other psychotropic classes. Connecticut, by centralizing authority to consent in its child welfare agency and mandating preconsent review by a psychiatrist of particularly risky prescriptions, comes closest to the most efficient mechanism for protecting foster children from the improper use of psychotropic drugs.

V.
CENTRALIZING AUTHORITY TO CONSENT IN THE CHILD WELFARE AGENCY

There are several parties who could act as medical consenters for children in foster care. The child him- or herself, biological parents with intact rights, judges, and the state child welfare agency are the most frequently discussed candidates.

A. The Child

Some commentators argue that children above a certain age should have absolute authority to give or withhold consent to treatment with psychotropic drugs.[223] Proponents of this policy claim that children age fourteen and older are cognitively capable of understanding the risks and benefits associated with psychotropic medication.[224] They also make a moral argument, claiming that the child should have the legal right to consent because the child will be the one to bear the consequences of taking the drug.[225] Finally, some commentators point to a practical benefit of allowing the

222. *See* discussion *infra* Parts V.B–C.

223. Brandow, *supra* note 23, at 1163.

224. *Id.* at 1168; *see also* LESLIE ET AL., EXAMINATION OF THE *ROGERS* PROCESS, *supra* note 140, app. at 12 ("I think as kids get older, they will have more say in what's going on in their lives. There is certainly a developmental trajectory of increasing capacity approaching the age of maturity. You absolutely want to hear what the kid's preferences are.").

225. Brandow, *supra* note 23, at 1173; *see also* LESLIE ET AL., EXAMINATION OF THE *ROGERS* PROCESS, *supra* note 140, app. at 6 ("Kids are not puppets—they need to know what they are taking and why.").

child to consent: patients who consent are more likely to comply with their medication regimens, increasing the chance of treatment success.[226]

While the desire to give a foster child a voice in his or her own medical affairs is commendable, granting the child authority to consent will not advance this goal. In states that give legal effect to a child's lack of consent, observers report that children are unlikely to know that they have the right to refuse treatment.[227] Those children who do exercise this right may be subject to retaliation from caregivers who want medication to control disruptive behaviors.[228] Furthermore, states have a variety of mechanisms to circumvent a child's lack of consent.[229] In Tennessee, where children sixteen and older can consent,[230] the state may seek judicial intervention when a child refuses a medication that the state has concluded is "necessary to protect the child from harm."[231] Similar procedural tools exist in Pennsylvania[232] and California.[233] The result of a policy locating power to consent in the child is likely to be the administration of the psychotropic drug, whether or not the child truly consents.

B. The Biological Parents

Some states allow a biological parent whose parental rights are still intact to consent to a foster child's medical treatment.[234] Proponents of this policy argue that it is constitutionally mandated, pointing to the Supreme Court's observation in *Santosky v. Kramer* that "[t]he fundamental liberty interest of natural parents in the care, custody, and management of their child does not evaporate

226. Brandow, *supra* note 23, at 1177; *see also* LESLIE ET AL., EXAMINATION OF THE *ROGERS* PROCESS, *supra* note 140, app. at 25 ("[Youth] need to be well informed or they won't take the medication, and then nobody wins.").

227. *See* Strawbridge, *supra* note 46, at 277 (noting that foster children are probably unaware that they can object to treatment); *The Drugging of Foster Youth*, *supra* note 17 (claiming that most California foster youth are unaware they have the right to refuse treatment with psychotropic medication).

228. *See The Drugging of Foster Youth*, *supra* note 17 (reporting that foster children who refuse to take psychotropic drugs are punished by group home workers).

229. WORTHINGTON, *supra* note 31, at 25.

230. *See supra* notes 160–61 and accompanying text.

231. TENN. DEP'T OF CHILDREN'S SERVS., ADMINISTRATIVE POLICIES AND PROCEDURES 20.24, *supra* note 160.

232. *See* 55 PA. CODE § 3680.52(6) (1987).

233. *See* LESLIE ET AL., EXAMINATION OF THE *ROGERS* PROCESS, *supra* note 140, app. at 38.

234. Such states include Alabama, Arizona, Kansas, Kentucky, and New Jersey. Naylor et al., *supra* note 133, at 181.

simply because they . . . have lost temporary custody of their child to the State."[235] Proponents also note that most children ultimately return to their families of origin after a stay in foster care.[236] As such, biological parents should be as involved as possible in a foster child's medical treatment in order to ensure continuity of care.

However, parents who have lost their children to foster care are unlikely to be able to effectively assert their right to withhold consent. Some parents have reported that they signed consent forms despite being unconvinced of the necessity of medication because they hoped to regain custody of their children.[237] One parent asked, "What can I say about it? If I protest, they'll say I don't care about the kids."[238] Moreover, states frequently have recourse to the judiciary when a parent makes a decision with which the state disagrees. For example, North Carolina's Division of Social Services can seek a court order when it strongly disagrees with a biological parent's choice to withhold consent.[239] Similar rules exist in Pennsylvania[240] and West Virginia.[241] Just as policies giving foster children power to consent will not reduce the likelihood of overmedication, policies empowering the biological parents of foster children are not suited to address the psychotropic medication crisis.

C. Judges

Several states require court authorization prior to the administration of at least certain classes of psychotropic medications to foster children.[242] Proponents of this policy believe that a judge should make medical decisions for foster children because he or she is most likely to have the children's best interests at heart.[243] The judge is thought to be a neutral player in the system surround-

235. 455 U.S. 745, 753 (1982).

236. LESLIE ET AL., EXAMINATION OF THE *ROGERS* PROCESS, *supra* note 140, app. at 25 ("[W]hat we see, is kids go back to their biological family when they turn 18. What sense does it make to cut [the biological parents] out when that is what is happening[?]").

237. Weber, *supra* note 21.

238. *Id.*

239. Kelley et al., *supra* note 83, at 39.

240. *See In re* W.H., 25 A.3d 330, 337 (Pa. Super. Ct. 2011) (noting that the juvenile court could override a biological mother's objection to the administration of psychotropic medication "if [the child's] psychiatrist believed that [the child's] condition required prompt medical treatment").

241. WORTHINGTON, *supra* note 31, at 22–23.

242. Naylor et al., *supra* note 133, at 182.

243. *2008 Hearing*, *supra* note 46, at 87 (statement of Jody Leibman Green, Policy Director, Children's Law Center of Los Angeles).

ing foster children, someone who does not approach the request with a bias for or against medicating.[244] Furthermore, unlike the child or the child's biological parents, a judge has enough independence to resist the myriad pressures to medicate.[245]

Nevertheless, judges are ineffective advocates for foster children's best interests. Most judges lack both a medical background and familiarity with any given foster child, making them overly reliant on state-commissioned psychiatrist's reports and caseworker-generated observations of the child's behavior.[246] As a result, judges typically follow the prescribing physician's recommendations, turning court authorization into a rubber stamp.[247] In addition, the judicial approval process generates ill will among the people involved in the foster child's care. Prescribing physicians resent having to testify before the court and often feel that their professional judgment is under attack.[248] Judges sometimes do not understand why they are charged with making the final decision and would prefer to wash their hands of the matter.[249] Court authorization creates more problems than it solves, costing time, money, and aggravation

244. *See* LESLIE ET AL., EXAMINATION OF THE *ROGERS* PROCESS, *supra* note 140, app. at 20 ("I think the judicial oversight is a critical piece. This ensures that there is neutral oversight in the administration process, to make sure these medications are not used for other than a medical need . . . .").

245. *See id.* at 8, 12 (discussing the importance of judicial immunity).

246. *See In re* J.C., No. CO46722, 2004 WL 2944669, at *4 (Cal. Ct. App. Dec. 21, 2004) (observing that "the only evidence before the juvenile court was the informed professional opinion of a qualified child psychiatrist"); GABRIEL MYERS WORK GROUP, *supra* note 61, at 25 (claiming that judges "lack . . . 'the intimacy of daily association' with the affected foster children" required to make medical decisions); *The Drugging of Foster Youth*, *supra* note 17 (noting that the judges "can only go by the reports handed to [them] by . . . social worker[s] and group home staff").

247. Strawbridge, *supra* note 46, at 281; *see also* LESLIE ET AL., EXAMINATION OF THE *ROGERS* PROCESS, *supra* note 140, app. at 21 (reporting that one judge "emphasized that he 'never feels comfortable' rejecting a proposed treatment plan because of the potential consequences of his denial"). *But see* LESLIE ET AL., EXAMINATION OF THE *ROGERS* PROCESS, *supra* note 140, app. at 5 (claiming that some judges "operate with a 'rubber stamp,' while others carefully review every case").

248. Merritt, *supra* note 6, at 4.

249. *See* Miller, *supra* note 81 (noting that Florida judges reported that they were "confused about their role"); Weber, *supra* note 21 (quoting Terry Friedman, former Presiding Judge of the Los Angeles Juvenile Court, as stating that "[w]e all have enormous fears that our decisions, one way or another, are going to cause serious harm to these children").

and producing the same results as would have obtained absent judicial involvement.[250]

D. The Child Welfare Agency

More than ten states place authority to consent in their child welfare agencies.[251] Of these states, most allow representatives of the agency, such as caseworkers, to make the decision.[252] Others have special departments within the agency tasked with consenting to treatment.[253] Either approach, when paired with preconsent review by medical professionals trained in child and adolescent psychiatry, is preferable to consent by the child, biological parents, or judges.

Authorizing the agency to consent vastly simplifies what would otherwise be a complicated, lengthy process. In systems that give the child or biological parents the power to consent, either consent is granted or else authorization to treat is obtained in some other, more time-consuming, fashion.[254] In systems that use court authorization, filing the appropriate paperwork, scheduling and conducting a hearing, and waiting for the judge to issue an order can take months.[255] Submitting a medication request to the child welfare agency has the advantage of being relatively quick and painless for the parties involved.[256] In addition, agency consent forces the child welfare bureaucracy to take ownership of prescription patterns in the foster care population. When the agency, rather than the children or their biological parents, is the medical consenter, it cannot shirk responsibility for adverse outcomes.

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250. *See* LESLIE ET AL., EXAMINATION OF THE *ROGERS* PROCESS, *supra* note 140, app. at 16 ("A collaborative approach is a great idea, but doctors, lawyers, and judges speak in two different languages and anyone resents having someone encroach on their expertise. . . . [W]ould judges want doctors telling them how to make judicial decisions?").

251. Such states include Alaska, Arkansas, Georgia, Maryland, Nebraska, Texas, Vermont, and Washington. Naylor et al., *supra* note 133, at 181.

252. Alaska, Arkansas, Georgia, Maryland, Nebraska, Vermont, and Washington allow caseworkers to consent. *Id.*

253. *See, e.g.*, discussion *supra* Part IV.A (describing such a department in Illinois).

254. *See supra* Parts V.A–B.

255. *See supra* text accompanying note 201.

256. Siegel, *supra* note 206, at 19; *see also* Soc. Justice Program, Ne. Univ. Sch. of Law, *supra* note 189, at 25 ("I like [the] idea of having some kind of quick, accessible panel that's available. . . . I think they should have the ability to review medical histories, authorize administration, and then start having some kind of monitoring system . . . .").

To be sure, there are drawbacks to designating the agency as the medical consenter. Much like judges, child welfare officials do not really know any given foster child very well.[257] Social workers handling high caseloads and special consent departments processing several medication requests each day cannot be expected to have in-depth knowledge of a specific child's circumstances.[258] Unfortunately, however, the foster children who most need protection from overmedication are often the ones who have no one in their lives who really knows them: their biological parents are unable or unwilling to be involved, their caseworkers are overburdened, and they change placements too frequently to form strong bonds with caretakers.[259] For these children, the decision whether or how to medicate is inevitably going to be made by a party who is less than fully acquainted with the details of their lives.

The more pressing concern is that the agency, faced with the demands of foster parents and other caregivers, will be too willing to medicate.[260] This criticism is valid, as child welfare personnel have reported feeling compelled to seek psychotropic drugs in order to maintain children in their placements.[261] Nevertheless, this should not disqualify the agency from acting as the medical consenter for children in foster care. When agency consent is combined with a preconsent review process, it both retains its advantages relative to other consent schemes and guards against overmedication of the foster population.

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257. Brandow, *supra* note 23, at 1162.

258. *Id.*

259. *See* AM. ACAD. OF CHILD & ADOLESCENT PSYCHIATRY, AACAP POSITION STATEMENT ON OVERSIGHT OF PSYCHOTROPIC MEDICATION USE FOR CHILDREN IN STATE CUSTODY: A BEST PRINCIPLES GUIDELINE 1 (2005) [hereinafter AM. ACAD. OF CHILD & ADOLESCENT PSYCHIATRY, AACAP POSITION STATEMENT], *available at* https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/systems_of_care/FosterCare_BestPrinciples_FINAL.pdf ("Unlike mentally ill children from intact families, [foster] children often have no consistent interested party to provide informed consent for their treatment, to coordinate treatment planning and clinical care, or to provide longitudinal oversight of their treatment."); Camp, *supra* note 60, at 380 (worrying that "an involved, committed, and informed adult will not be available (or willing) to make an informed decision" about the treatment of a foster child with psychotropic medication); Setless, *supra* note 34, at 615 (claiming that "a stable and devoted adult is almost always absent" from the life of a foster child).

260. Brandow, *supra* note 23, at 1162.

261. *See supra* note 57.

VI.
PRECONSENT REVIEW BY MEDICAL PROFESSIONALS TRAINED IN CHILD AND ADOLESCENT PSYCHIATRY

Preconsent review requires a medical professional trained in child and adolescent psychiatry to assess the appropriateness of a prescription before the agency can give consent. Different approaches to preconsent review are possible. States can create positions within their child welfare agencies for child and adolescent psychiatrists[262] or establish partnerships with local universities.[263] States can mandate that every review be conducted by psychiatrists or allow other medical professionals, like APRNs, to handle more routine cases.[264] Finally, states can require review of every psychotropic drug request or just those that raise red flags.[265] The ultimate goal is to get a neutral third party with expertise in child and adolescent psychiatry to identify dangerous prescriptions, initiate conversations with prescribing physicians, and gradually eliminate the worst abuses from the system.

For states struggling with budgetary constraints, red flag review is more feasible than a system requiring scrutiny of every prescription.[266] Red flags are "[p]atterns that may signal that factors other than clinical need are impacting the prescription of psychotropic

262. As Connecticut did. Siegel, *supra* note 206, at 3. There are drawbacks to this approach, however. *See* Patricia K. Leebens, *Mental Health Consultation within State Child Agency*, PALTECH 19, http://www.pal-tech.com/web/psychotropic/documents/Workshop%206%20-%20Leebens.pptx (last visited Nov. 2, 2014) (noting that a psychiatrist employed by a state agency "[c]an be co-opted by political forces which demand . . . sole allegiance to the state agency rather than to children and families" and observing that the position may come with "budgetary limitations which compromise . . . effectiveness and/or . . . professional standards").

263. As Illinois did. Siegel, *supra* note 206, at 4.

264. *See supra* notes 210–11 and accompanying text.

265. *Compare 2007 Hearing*, *supra* note 117, at 30 (statement of Michael W. Naylor, Director, Division of Child & Adolescent Psychiatry, Program Institute for Juvenile Research, University of Illinois-Chicago) (describing the Illinois system, which requires review of every prescription), *with* Naylor et al., *supra* note 133, at 182–83 (describing the Tennessee system, which confines reviews to riskier prescriptions).

266. *See 2011 Hearing*, *supra* note 24, at 182 (statement of the Bazelon Center for Mental Health Law) (endorsing reviews of prescriptions "for . . . 5 or more medications or 2 or more medications from the same class"); N.Y. OFFICE OF CHILDREN & FAMILY SERVS., *supra* note 16, at 13 (recommending that New York districts implement a red flag system); CARTER, *supra* note 8, at 39 (describing efforts in Georgia to "create procedures for independent clinical reviews to be triggered when a prescription falls outside of the medication guidelines").

medications."[267] Texas was the first state to develop a list of red flags[268] and other states with red flag policies have tended to follow its lead.[269] The Texas parameters, revised in 2013, recommend review of a child's medication regimen under the following circumstances:

1. Absence of a thorough assessment for the DSM-5 diagnosis(es) in the child's medical record[.]
2. Four (4) or more psychotropic medications prescribed concomitantly (side effect medications are not included in this count)[.]
3. Prescribing of:
   Two (2) or more concomitant stimulants[;]
   Two (2) or more concomitant alpha agonists[;]
   Two (2) or more concomitant antidepressants[;]
   Two (2) or more concomitant antipsychotics[; or]
   Three (3) or more concomitant mood stabilizers[.]
4. The prescribed psychotropic medication is not consistent with appropriate care for the patient's diagnosed mental disorder . . . .
5. Psychotropic polypharmacy . . . for a given mental disorder is prescribed before utilizing psychotropic mono-therapy.
6. The psychotropic medication dose exceeds usual recommended doses (FDA and/or literature based maximum dosages).
7. Psychotropic medications are prescribed for children of very young age, including children receiving the following medications with an age of:
   Stimulants: Less than three (3) years of age[;]
   Alpha Agonists[:] Less than four (4) years of age[;]
   Antidepressants: Less than four (4) years of age[;]
   Antipsychotics[:] Less than four (4) years of age[; or]

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267. ADMIN. FOR CHILDREN & FAMILIES, U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 18, at 8.

268. PSYCHOTROPIC MEDICATION ROUNDTABLE, SUP. CT. OF TEX. PERMANENT JUDICIAL COMM'N FOR CHILDREN, YOUTH & FAMILIES, PSYCHOTROPIC MEDICATION AND TEXAS FOSTER CARE 12 (2012), *available at* http://texaschildrenscommission.gov/media/15003/Final%20Psych%20Meds%20Report%20PRINT_01-10-13.pdf.

269. *See, e.g.*, *Tennessee Begins Tracking Medications for Children in State Custody*, CHILDREN'S VOICE (Nov.–Dec. 2008), http://www.cwla.org/voice/0811national.htm (reporting that Tennessee's psychotropic medication guidelines were based on the Texas parameters); Admin. on Children, Youth, & Families, *"Too Many, Too Much, Too Young": Red Flags on Medications and Troubled Children*, 21 RECLAIMING CHILDREN & YOUTH, Summer 2012, at 59, 61 (2012) (listing red flags that resemble the Texas parameters).

Mood Stabilizers: Less than four (4) years of age[.]

8. Prescribing by a primary care provider who has [no] documented previous specialty training for a diagnosis other than the following (unless recommended by a psychiatrist consultant):

Attention Deficit Hyperactive Disorder (ADHD)[;]

Uncomplicated anxiety disorders[; or]

Uncomplicated depression[.]

9. Antipsychotic medication(s) prescribed continuously without appropriate monitoring of glucose and lipids at least every 6 months.[270]

Red flag preconsent review can counteract some of the pressures to medicate emanating from drug manufacturers, foster parents, and school personnel.[271] States that have experimented with such reviews have reported promising results. Texas saw a 31% drop in the concurrent use of five or more psychotropic classes per child in its foster care population.[272] Washington has also reduced the number of high-risk prescriptions issued to foster children using a red flag approach.[273] Other states have noted lower proposed dosages and a decrease in requests for antipsychotics for young children.[274] Despite a record of success, there are obstacles standing in the way of nationwide implementation of red flag preconsent review systems. These include intellectual objections to the scheme, such as concerns about protecting the sanctity of the doctor/patient relationship and maintaining unrestricted access to mental health treatment, as well as political realities, such as the power of the pharmaceutical industry and the cost of conducting preconsent reviews.

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270. TEX. DEP'T OF FAMILY & PROTECTIVE SERVS. & UNIV. OF TEX. AT AUSTIN COLL. OF PHARMACY, PSYCHOTROPIC MEDICATION UTILIZATION PARAMETERS FOR CHILDREN AND YOUTH IN FOSTER CARE 8 (2013), *available at* http://www.dfps.state.tx.us/documents/Child_Protection/pdf/TxFosterCareParameters-September2013.pdf.

271. *See* Camp, *supra* note 60, at 400 (noting that preconsent review enhances the "neutrality and legitimacy of recommended treatment").

272. *2008 Hearing*, *supra* note 46, at 10 (statement of Julie M. Zito, Professor of Pharmacy & Psychiatry, Pharmaceutical Health Services Research, University of Maryland).

273. *2011 Hearing*, *supra* note 24, at 123 (statement of Dr. Jon McClellan, Child Psychiatrist, Seattle Children's Hospital).

274. Mello, *supra* note 22, at 426.

A. The Sanctity of the Doctor/Patient Relationship

Opponents of red flag preconsent review argue that a preconsent review process infringes on the doctor/patient relationship. They view with suspicion any effort to insert the state into a clinical encounter.[275] They also question the value of giving oversight power to psychiatrists who only know the patient on paper, claiming that these professionals could not possibly be better equipped than the child's own doctor to make treatment decisions.[276] Doctors are especially worried that the state will use preconsent review to dictate the decisions of treatment providers, and they have been able to use their political influence to block reform in some states.[277]

These objections, however, are ill founded. When the patient is a minor, the relationship at issue is really between the doctor and the parent or guardian. In most cases, minors are considered legally incompetent[278] and cannot provide or withhold consent to medical treatment.[279] Responsibility to consent, therefore, falls to the minor's parent or guardian.[280] Parents and guardians are given the power to consent because it is assumed that they love their children and will act in their children's best interests.[281]

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275. *2011 Hearing*, *supra* note 24, at 22 (statement of Matt Salo, Executive Director, National Association of State Medicaid Directors).

276. *See* LESLIE ET AL., MULTI-STATE STUDY, *supra* note 57, at 14 (noting that some states locate authority to consent at the clinical encounter to address concerns about personalization of care).

277. *See, e.g.*, *The Drugging of Foster Youth*, *supra* note 17 (noting that a California bill that would have required the Department of Social Services to study the administration of psychotropic drugs to foster children was killed due to opposition from the California Psychiatric Association).

278. Stephen A. Talmadge, *Who Should Determine What Is Best for Children in State Custody Who Object to Psychotropic Medication?*, 15 ANNALS HEALTH L. 183, 201 (2006).

279. Christine M. Hanisco, Note, *Acknowledging the Hypocrisy: Granting Minors the Right to Choose Their Medical Treatment*, 16 N.Y.L. SCH. J. HUM. RTS. 899, 899 (2000).

280. AM. ACAD. OF CHILD & ADOLESCENT PSYCHIATRY, CODE OF ETHICS 5 (2009), *available at* http://www.aacap.org/App_Themes/AACAP/docs/about_us/transparency_portal/aacap_code_of_ethics_2012.pdf; COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, AM. MED. ASS'N, CEJA REPORT 8-I-07, PEDIATRIC DECISION-MAKING 1 (2007), *available at* http://www.ama-assn.org/resources/doc/code-medical-ethics/10016a.pdf.

281. RICHARD B. MILLER, CHILDREN, ETHICS, AND MODERN MEDICINE 39–40 (David H. Smith & Robert M. Veatch eds., 2003); Richard E. Redding, *Children's Competence to Provide Informed Consent for Mental Health Treatment*, 50 WASH. & LEE L. REV. 695, 697 (1993); Matthew S. Feigenbaum, Comment, *Minors, Medical Treat-*

In the foster care context, the state assumes the role of parent[282] and has the same duty to pursue the best interests of the children in its care.[283] Even though the state's responsibilities to the children in its care are well understood,[284] it is extremely difficult for the state to meet its obligations. The state agent who most resembles a parent to a foster child is probably the caseworker. Many caseworkers, however, are already struggling to manage caseloads that far exceed CWLA recommendations, and thus cannot form close bonds with any given child.[285] Consequently, it is highly unlikely that they will act with the same caution a prudent parent would exhibit in deciding whether to put a child on psychotropic medication.[286] Even if caseworkers did wish to take a cautious approach to medication, they lack the medical training necessary to identify inappropriate prescriptions and persuade the prescribing physician to alter the treatment plan.[287]

While obviously not a perfect substitute for the concern of a loving parent, red flag preconsent review can help the state better approximate the role of a caring guardian. It puts experts in child and adolescent psychiatry between a prescribing physician and the state agent authorized to consent, allowing the experts to supply some of the caution that is inevitably missing from the state's approach to the question of whether or how to medicate a foster

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ment, and Interspousal Disagreement: Should Solomon Split the Child?, 41 DEPAUL L. REV. 841, 853 (1992).

282. Brandow, *supra* note 23, at 1152 (noting that foster children are under the parens patriae power of the state).

283. *See* Mindy S. Rosenberg & Robert D. Hunt, *Child Maltreatment: Legal and Mental Health Issues*, *in* CHILDREN, MENTAL HEALTH, AND THE LAW 79, 85 (N. Dickon Reppucci et al. eds., 1984) (arguing that the parens patriae power must be exercised to promote the child's best interests); Mello, *supra* note 22 ("[T]he state must care for and treat [foster] children as a prudent parent would.").

284. *See 2008 Hearing*, *supra* note 46, at 3 (statement of Rep. McDermott, Member, H. Comm. on Ways & Means) ("When at-risk children are taken into custody for their own safety, they become foster children and we become their parents."); LESLIE ET AL., EXAMINATION OF THE *ROGERS* PROCESS, *supra* note 140, at 21 (arguing that the state must "mimic the role of a responsive parent or caretaker" when making decisions on psychotropic medications).

285. *See* Talmadge, *supra* note 278, at 183.

286. CHILD WELFARE INFORMATION GATEWAY, CASELOAD AND WORKLOAD MANAGEMENT 3 (2010), *available at* https://www.childwelfare.gov/pubs/case_work_management/case_work_management.pdf; Strawbridge, *supra* note 46, at 268–69.

287. Camp, *supra* note 60, at 403; Christopher Bellonci & Thomas I. Mackie, Oversight of Psychotropic Medication Use among Youth in Custody of State Child Welfare Systems 46 (Oct. 2011) (unpublished PowerPoint presentation) (on file with author).

child.[288] Even doctors concerned about infringements on their prescribing freedoms are capable of acknowledging that some oversight is needed to protect children in foster care,[289] and many doctors have indicated a preference for oversight by fellow physicians, rather than by social workers or lawyers.[290] Red flag preconsent review has the dual advantages of being politically palatable and capable of protecting foster children from abusive prescription practices.[291]

B. Preconsent Review as an Obstacle to Treatment

Critics also worry that the preconsent review process will delay or impede access to psychiatric treatment in the foster care system.[292] Opponents of preconsent review prioritize quick responses to behavioral and mental health issues over protracted assessments of proposed treatments, arguing that it is cruel to allow foster children to suffer while the bureaucracy processes their medication requests.[293] They urge the importance of early intervention, claiming that childhood mental illnesses left untreated can interfere with school performance and the acquisition of social skills.[294] More

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288. *See* Strawbridge, *supra* note 46, at 285 (arguing that Tennessee's system "allows [the state] to make up for the lack of parental concern by applying the cautiousness of a medical professional").

289. LESLIE ET AL., EXAMINATION OF THE *ROGERS* PROCESS, *supra* note 140, app. at 9 (quoting a healthcare professional as stating that "[i]f those kids don't have parents to look out for them because they're in state custody, there should be a process for someone to provide oversight").

290. *See* CONN. DEP'T OF CHILDREN & FAMILIES, GUIDELINES, *supra* note 207, at 11 (noting that prescribing physicians respond better to oversight when allowed to interact directly with fellow medical professionals); Merritt, *supra* note 6, at 12, 19, 21 (arguing that because psychiatrists and lawyers understand medication and its side effects differently, psychiatrists would prefer submitting medication requests to an agency consent panel staffed by physicians).

291. *See* CONN. DEP'T OF CHILDREN & FAMILIES, POLICY 44-5-2.1, *supra* note 209 ("[T]he standard of care in most states is for mental health professionals to provide assistance to the state's child welfare agency regarding the informed consent process for the use of psychotropic medications.").

292. AM. ACAD. OF CHILD & ADOLESCENT PSYCHIATRY, AACAP POSITION STATEMENT, *supra* note 259; BECCI AKIN ET AL., MEDICAID CHILDREN'S FOCUSED STUDY: PRESCRIBING PATTERNS OF PSYCHOTROPIC DRUGS AMONG CHILD MEDICAID BENEFICIARIES IN THE STATE OF KANSAS 13 (2009), *available at* http://www.keys.org/kureports/finalreportdrugs.pdf.

293. *See* GRUTTADARO & MILLER, *supra* note 111, at 12 (stressing the importance of avoiding "prolonged delays in receiving appropriate treatment").

294. *See* LESLIE ET AL., EXAMINATION OF THE *ROGERS* PROCESS, *supra* note 140, at 16 ("[H]ealth care providers emphasized the notion that the best interest of the child requires a process that assures clinical services are provided as quickly as

generally, critics argue that psychotropics are not the evils they are often made out to be, as recent years have seen the development of drugs that are safer and more effective than ever before.[295] Foster children do not need to be protected from these drugs; on the contrary, too many foster children go without appropriate medications and a preconsent review process will only exacerbate this problem.[296]

Claims that foster children are undermedicated are dubious in light of the data available on the subject.[297] Even assuming that foster children are at risk of being denied needed drugs, a red flag preconsent review system would only target an especially risky subset of psychotropic prescriptions. Prescriptions that appear safe, such as those for a low dose of a single drug for an older child, would not raise a red flag and would not require preconsent review.[298] Prescriptions that seem more dangerous, such as those for very young children or written by a physician with no training in psychiatry, would be the only ones singled out for further inspection.[299] All a red flag preconsent review system proposes is giving some extra scrutiny to "non-standard, unusual, and/or experimental psychiatric interventions" before administering them to foster children.[300] Furthermore, the review process does not have to be inflexible or lengthy. As multiple states have demonstrated, it is possible to implement review systems featuring short turnaround times and exceptions for emergencies.[301]

C. The Influence of Drug Manufacturers

The pharmaceutical industry disfavors legal restrictions on prescribing practices and has not hesitated to use its political clout to block reform efforts.[302] Nevertheless, the experience of Washing-

possible in order to meet the pressing mental health needs of youth in [state] custody.").

295. *See* GRUTTADARO & MILLER, *supra* note 111, at 8 (worrying that "[a]nti-psychiatry groups" have advanced "unfounded assertions" about the dangers of psychotropic drugs).

296. *See id.* at 14 (claiming that 80% of mentally ill youth receive no mental health treatment).

297. *See supra* Part III.A.

298. *See* TEX. DEP'T OF FAMILY & PROTECTIVE SERVS. & UNIV. OF TEX. AT AUSTIN COLL. OF PHARMACY, *supra* note 270.

299. *Id.*

300. *2008 Hearing*, *supra* note 46, at 50 (statement of Christopher Bellonci, Medical Director, the Walker School).

301. *See supra* Parts IV.A–B, IV.E.

302. *2011 Hearing*, *supra* note 24, at 22 (statement of Matt Salo, Executive Director, National Association of State Medicaid Directors).

ton state indicates that pharmaceutical lobbying is not an insurmountable obstacle. Washington faced opposition from drug manufacturers when it began the process of implementing a red flag review system, but was able to neutralize much of the resistance by publicizing alarming data on the high-risk prescriptions that were being issued to foster children.[303] In the end, the pharmaceutical industry's lobbying did not result in any substantive changes to the proposed monitoring system.[304] Shocking statistics and anecdotes from across the country should provide similar support for nationwide reform.[305]

D. The Cost Burden of Preconsent Review

Opponents of preconsent review may also cite cost as a concern, worrying that the expenses associated with the reviews will strain state budgets. While it is true that hiring medical professionals to conduct reviews will require an expenditure of state funds, preconsent review actually has the potential to create cost savings in the short and long term. In the short term, preconsent review can reduce the number of psychotropic medications the state must purchase for the children in its care.[306] This is an especially important advantage given the increasing popularity of expensive atypical antipsychotics as a treatment option for foster children.[307] In the long term, preconsent review can give children in foster care the opportunity to become productive members of society. By ensuring proper treatment of mental health issues in the foster population, these reviews can help foster children avoid events like hospitalization, institutionalization, and interruptions in schooling that might otherwise disrupt their development.[308]

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303. *Id.* at 156 (statement of Dr. Jon McClellan, Child Psychiatrist, Seattle Children's Hospital).

304. *Id.*

305. *See supra* Parts III.A, IV.B.

306. *See supra* notes 272–74 and accompanying text; *see also 2011 Hearing*, *supra* note 24, at 24 (statement of Dr. Jon McClellan, Child Psychiatrist, Seattle Children's Hospital) (claiming that Washington's red flag system saved the state $1.2 million over two years).

307. *See* Crystal et al., *supra* note 38 (observing that antipsychotics are "the most costly drug class for Medicaid programs, exceeding the runner-up (antidepressants) by a wide margin").

308. *See 2011 Hearing*, *supra* note 24, at 161 (statement of the National Alliance on Mental Illness) (arguing that the provision of effective psychosocial interventions to foster children generates long-term savings).

VII.
A FEDERAL SOLUTION

The federal government is uniquely positioned to spur reform across the country. By tying access to federal funds to implementation of red flag preconsent review systems that use the Texas criteria, the federal government can pressure every state to confront the psychotropic medication crisis.

A. State Dependence on Federal Funds

The federal government has shared the cost of foster care with the states since 1961.[309] Under Title IV-E of the Social Security Act, states may claim reimbursement for costs associated with the daily care and supervision of foster children; the administration of a foster care program; the training of staff and foster care providers; and the design, implementation, and operation of a statewide data collection system.[310] In 2011, the federal government spent more than $6 billion through Title IV-E, covering over half of the states' Title IV-E spending.[311] The Department of Health and Human Services is authorized to withhold reimbursement from states that do not comply with federal law.[312] Incorporating a red flag preconsent review requirement into federal law should produce real reform in the states that have not adequately addressed the psychotropic drug crisis, as the threat of losing federal funding would induce state lawmakers to pay serious attention to the issue.

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309. Office of the Assistant Sec'y for Planning & Evaluation, U.S. Dep't of Health & Human Servs., ASPE Issue Brief: Federal Foster Care Financing 3 (2005), *available at* http://aspe.hhs.gov/hsp/05/fc-financing-ib/ib.pdf.

310. *Title IV-E Foster Care*, Children's Bureau (May 17, 2012), http://www.acf.hhs.gov/programs/cb/resource/title-ive-foster-care.

311. Emilie Stoltzfus, Cong. Research Serv., R42792, Child Welfare: A Detailed Overview of Program Eligibility and Funding for Foster Care, Adoption Assistance and Kinship Guardianship Assistance under Title IV-E of the Social Security Act 1 (2012), *available at* http://greenbook.waysandmeans.house.gov/sites/greenbook.waysandmeans.house.gov/files/2012/documents/R42792_gb_2.pdf.

312. *See* 45 C.F.R. § 1355.33 (2012) (describing Child & Family Services Reviews, which the federal government uses to monitor state compliance with federal law); Children's Bureau, U.S. Dep't of Health & Human Servs., Child and Family Services Reviews Procedures Manual 5 (2006), *available at* http://www.acf.hhs.gov/sites/default/files/cb/cfsr_procedures_manual.pdf (explaining that federal funds may be withheld for nonconformity with federal law).

B. Fears of Federalization

Critics of further federal involvement in foster care express skepticism that a uniform solution to the psychotropics issue can be applied to all states.[313] Opponents argue that each state differs in its foster care population, its resource base, and the severity of its psychotropic drug problem, making federal legislation an inappropriate approach to the crisis.[314] They are also concerned about the effect federal intervention could have on state experimentation. They view states as the laboratories of democracy, constantly testing new policy approaches to discover what does and does not work.[315] A federal law mandating that each state adopt a red flag preconsent review system would put an end to this beneficial experimentation, perhaps preventing states from discovering an even better solution.[316]

Nevertheless, many observers deem a national approach to foster care's psychotropics problem both appropriate and necessary.[317] Without federal involvement, states will not make much progress unless prompted by a tragedy or a lawsuit.[318] The benefits of allowing states to continue experimenting with new policies must be balanced against the dangers psychotropic drugs pose to the wellbeing of children in foster care. At a certain point, experimen-

313. *See, e.g.*, *2008 Hearing*, *supra* note 46, at 62 (statement of Christopher Bellonci, Medical Director, the Walker School & Laurel K. Leslie, Developmental-Behavioral Pediatrician, Center on Child & Family Outcomes, Tufts-New England Medical Center Institute for Clinical Research & Health Policy Studies).

314. *See* ADMIN. FOR CHILDREN & FAMILIES, U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 18, at 13 (observing that each state's "service delivery array is unique").

315. *2011 Hearing*, *supra* note 24, at 3 (statement of Sen. Carper, Member, S. Comm. on Homeland Sec. & Governmental Affairs).

316. *See id.* at 150 (statement of Matt Salo, Executive Director, National Association of State Medicaid Directors) (expressing a desire to "maintain flexibility while bringing much needed awareness to this problem").

317. *See, e.g.*, *2007 Hearing*, *supra* note 117, at 61–62 (statement of Michael W. Naylor, Director, Division of Child & Adolescent Psychiatry, Program Institute for Juvenile Research, University of Illinois-Chicago) (recommending standardization of consent procedures across states); GABRIEL MYERS WORK GROUP, *supra* note 61, at 13 (endorsing the development of "a comprehensive nationwide approach" to the psychotropics problem); Leslie et al., *supra* note 24, at 17 (arguing that the psychotropic drug problem requires a national response).

318. *See* Matthew M. Cummings, Note, *Sedating Forgotten Children: How Unnecessary Psychotropic Medication Endangers Foster Children's Rights and Health*, 32 B.C. J.L. & SOC. JUST. 357, 388 (2012) (claiming that the overmedication of foster children with psychotropic drugs "needs prioritization on a national level"); Bellonci & Mackie, *supra* note 287 (naming "lack of national approach" as a complicating factor in the psychotropic drug crisis).

tation must cease and states must be prompted to adopt the practices that have worked best in other states.[319] Red flag preconsent reviews have produced results in several states, making them an ideal candidate for replication across the country.[320]

Furthermore, conditioning receipt of federal funds on implementation of a red flag preconsent review process does not have to completely stifle policy experimentation. Those states that wish to go beyond the Texas criteria by adopting a stricter set of red flags would be free to do so. Tennessee's medication utilization parameters, for example, flag for review the prescription of any psychotropic drug to a child under five years of age.[321] Nevada and Colorado are also more cautious than Texas, with Nevada targeting all off-label prescribing for extra scrutiny[322] and Colorado treating three or more concurrent prescriptions as a red flag.[323] Federal law can set a baseline, pushing reluctant states to provide some degree of protection while allowing ambitious states to implement more rigorous review mechanisms.[324]

CONCLUSION

Foster children face a perfect storm that ensures that large numbers of them will be inappropriately medicated with psychotropic drugs. They come into state custody burdened with histories of neglect or abuse and suffering from the effects of being sepa-

319. *See 2011 Hearing*, *supra* note 24, at 3 (statement of Sen. Carper, Member, S. Comm. on Homeland Sec. & Governmental Affairs) (describing the states as "laboratories of democracy" but arguing that "[e]very State should be adopting those practices" that have been shown to be effective elsewhere).

320. *See supra* notes 272–74 and accompanying text. Red flag preconsent review systems are also an ideal candidate for nationwide replication because private funding may be readily available for such programs. *See* Hunt, *supra* note 56 (reporting that "private foundations have expressed interest in funding the [red flag system] idea as a national pilot program").

321. PHARMACY & THERAPEUTICS COMM., TENN. DEP'T OF CHILDREN'S SERVS., *supra* note 18, at 6. New Mexico has the same policy. George Davis, *The Use of Psychotropic Medication in Children and Adolescents*, N.M. LEGISLATURE 7 (Sept. 2, 2013), http://www.nmlegis.gov/lcs/handouts/LHHS%20090413%20Item%207%20%20Davis%20MD%20Psychiatrist%20CYFD%20%20The%20Use%20of%20Psychotropic%20Medication%20in%20Children%20and%20Adolescents.pdf.

322. Nev. Rev. Stat. Ann. § 432B.197(1) (West 2009).

323. COLO. DEP'T OF HEALTH CARE POLICY & FIN. & COLO. DEP'T OF HUMAN SERVS., PSYCHOTROPIC MEDICATION GUIDELINES FOR CHILDREN AND ADOLESCENTS IN COLORADO'S CHILD WELFARE SYSTEM 6 (2013), *available at* http://www.colorado.gov/cs/Satellite/CDHS-ChildYouthFam/CBON/1251644597356.

324. *Cf.* WORTHINGTON, *supra* note 31, at 18 (explaining the virtues of "[f]ramework-setting legislation").

rated from their families of origin. Their responses to the traumas they have endured lead caretakers and doctors to turn to pharmaceutical solutions, either out of genuine concern for the child's mental health or simply out of a desire to control disruptive behavior. While a child from an intact family would enjoy the protection that comes from parental love, foster children too often have no one to advocate on their behalf. Consequently, they are medicated more frequently, and with more dangerous classes and combinations of drugs, than are children in the general population. While tragedies or class actions have pushed some states to confront the issue, the majority still have confused or nonexistent policies that leave many foster children unprotected.

The solution that holds the most promise entails locating authority to consent to medical treatment in the state child welfare agency and requiring preconsent review of riskier prescriptions by medical professionals trained in child and adolescent psychiatry. Designating the agency as the medical consenter simplifies the process while forcing the state to take responsibility for psychotropic drug use in the foster care population. Requiring red flag preconsent review reduces the number of risky prescriptions issued to foster children by facilitating dialogue between prescribing physicians and experts in child and adolescent psychiatry. Finally, federal involvement in promoting more widespread implementation of red flag preconsent review provides greater protection for foster children while leaving room for states to exceed the federally mandated minimum. With the causes and consequences of the psychotropics crisis clearer than ever, and an effective and politically plausible solution on the table, the time is right for the federal government to take action.