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American Bar Association Commission on Youth at Risk, Commission on Homelessness and Poverty, Health Law Section Report to the House of Delegates: Overuse of Psychotropic Medication Among Children and Youth in State Custody

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AMERICAN BAR ASSOCIATION
COMMISSION ON YOUTH AT RISK
COMMISSION ON HOMELESSNESS AND POVERTY
HEALTH LAW SECTION
REPORT TO THE HOUSE OF DELEGATES

RESOLUTION

RESOLVED, That the American Bar Association urges state, territorial, local and tribal child welfare and juvenile justice agencies to develop comprehensive policies that ensure children in the custody of child welfare and juvenile justice systems who need psychotropic medications are prescribed such medications only to treat mental and behavioral health conditions, only as medically necessary and not merely to control behavior, and that are developed in collaboration with best practice guidelines from medical professional organizations and medical, mental health and disability experts..

FURTHER RESOLVED, That the American Bar Association urges state, territorial, local and tribal courts to develop oversight protocols to ensure that these policies are implemented in child welfare and juvenile justice cases under their jurisdiction, and to ensure that medication regimens are evaluated, and, if appropriate, continue without interruption when placement changes occur or when the child is transitioning out of the foster care or juvenile justice systems.

FURTHER RESOLVED, That the American Bar Association urges attorneys, judges, bar associations, and law school clinical programs on children's issues to promote education and to develop technical assistance resources on legal issues related to psychotropic medications and on the appropriate use of psychotropic medication for children.

FURTHER RESOLVED, That the American Bar Association urges Congress to enact legislation requiring state, territorial and tribal governments to collect data and report to appropriate federal agencies on the ongoing use of psychotropic medication for children in foster care and in the juvenile justice system under their jurisdiction.

REPORT[1]
Introduction

Children in foster care and youth involved in the juvenile justice system are prescribed psychotropic medications at alarmingly high rates.[2] Foster children are given psychotropic medications at a rate nine times higher than children not in foster care.[3] And over fifty percent of the youth involved in the juvenile justice system are prescribed psychotropic medications within one month of intake.[4]

While psychotropic medications can be a useful part of a child's treatment plan, over-medication causes these children and youth to "act like zombies", contemplate harming themselves, or worse, commit suicide.[5] Additionally, the side effects of over-medication are endless. They can range from, but are not limited to, the less severe to the most extreme – anxiety, dizziness, confusion, and changes in behavior, to excessive weight gain, seizures, and death from liver failure.[6]

Children in foster care and youth in the juvenile justice system are overmedicated because they are often prescribed psychotropic medication: (1) without informed consent by the child, his/her parent, or the court-appointed guardian; (2) without the review of a full medical history and diagnostic assessment, without record keeping by the agency who has custody of the child, without protocols to monitor and review medication use on a short or long-term basis, and with inadequate court oversight; (3) to control behavior, often concomitantly with other psychotropic medication, in dosages exceeding the maximum recommendation, and for off-label

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[1] Allison Flood, Class of 2015 of the Maurice A. Deane School of Law at Hofstra University, researched and authored this report. The ABA Commission on Youth at Risk is grateful for her important contribution and excellent work.

[2] *See* 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, 373 (2011) (discussing the over-administration of psychotropic drugs to foster children as a nationwide epidemic); *see also* Camilla L. Lyons et al., *Psychotropic Medication Patterns Among Youth in Juvenile Justice*, 40 ADMIN. & POL'Y MENTAL HEALTH 58, 59 (2013).

[3] Dr. Mark Abdelmalek et al., *New Study Shows U.S. Government Fails to Oversee Treatment of Foster Children With Mind-Altering Drugs*, ABCNEWS (Nov. 30, 2011), http://abcnews.go.com/US/study-shows-foster-children-high-rates-prescription-psychiatric/story?id=15058380 (citing a 2010 study conducted by Rutgers University of nearly 300,000 foster children).

[4] *See* Lyons et al., *supra* note 2, at 59.

[5] *See Freed from a Pharmaceutical Fog, A Young Man's Life Changes*, CHILDREN'S RIGHTS (Aug. 5, 2011), http://www.childrensrights.org/news-events/cr-blog/freed-from-a-pharmaceutical-fog-a-young-mans-life-changes/; *see also Broward Child's Suicide Raises Questions About Medication*, ALLIANCE FOR HUMAN RESEARCH PROTECTION (Apr. 24, 2009), http://www.ahrp.org/cms/content/view/580/108/; *see also* JoAnne Solchany, *Psychotropic Medication and Children in Foster Care: Tips for Advocates and Judges*, AM. BAR ASS'N (Oct. 2011), *available at* http://www.americanbar.org/content/dam/aba/administrative/child_law/PsychMed.authcheckdam.pdf (acknowledging that these children and youth often have trauma and legitimate health conditions that do need attention).

[6] Citizens Comm'n on Human Rights Int'l, *A Report on the Side Effects of Common Psychiatric Drugs*, CCHR INT'L (2008), *available at* http://www.cchr.org/sites/default/files/The_Side_Effects_of_Common_Psychiatric_Drugs.pdf; *see also* Nat'l Institute of Mental Health, *Mental Health Medications*, NIMH (2008), *available at* http://www.nimh.nih.gov/health/publications/mental-health-medications/index.shtml.

use; and (4) without previous or concurrent use of any alternate therapies or psychosocial treatments.[7] Children in foster care and youth involved in the juvenile justice system are thereby denied their constitutional right to adequate medical care, including the right to avoid the over-administration of psychotropic medications.[8]

A number of organizations have weighed in on this issue. The American Academy of Child and Adolescent Psychiatry ("AACAP") created its Position Statement on the Oversight of Psychotropic Medication Use for Children in State Custody: A Best Principles Guideline, and the National Council of Juvenile and Family Court Judges ("NCJFCJ") passed a resolution in 2013, both of which are intended to improve the oversight and regulation of psychotropic medication use in the child welfare and juvenile justice systems.[9] The ABA Center on Children and the Law also published a practice and policy brief in 2011 for advocates and judges; the report concluded that children in care are especially vulnerable to the overuse of psychotropic medication and that medication use should be supported with other treatments and therapies to avoid any risk of harm to a child or youth in care.[10]

This resolution urges states and agencies that oversee child welfare and juvenile justice to develop comprehensive policies so that children and youth who need psychotropic medications are prescribed such medications only to treat mental and behavioral health conditions, only as medically necessary, and not merely to control behavior, and that these policies are developed in collaboration with best practice guidelines from medical professional organizations and medical, mental health and disability experts. Second, the resolution urges the implementation of court and agency oversight processes to insure that children in both systems receive appropriate treatment for mental health conditions and trauma, and that their treatment continues without interruption when placement changes occur or when children and youth transition out of either or both systems. The resolution further encourages attorney and judges to increase their education of the legal issues around psychotropic medication use in children. Finally, the resolution urges Congress to enact legislation that will require states to collect data and report on use of psychotropic medication for all children in state custody.

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[7] *See* Laura K. Leslie et al., *Multi-State Study on Psychotropic Medication Oversight in Foster Care*, TUFTS CLINICAL & TRANSNATIONAL SCIENCE INST. (Sept. 2010), *available at* http://www.tuftsctsi.org/~/media/Files/CTSI/Library%20Files/Psychotropic%20Medications%20Study%20Report.ashx; *see also* Barbara J. Burns et al., *Effective Treatment for Mental Disorders in Children and Adolescents*, 2 CLINICAL CHILD & FAM. PSYCHOL. REV. 199, 213-16 (1999) (discussing that a common side effect of psychotropic medications is sedation); KRISTIN G. CLOYES ET AL., PRESCRIPTION AND USE OF PSYCHOTROPIC MEDICATIONS IN UTAH DIVISION OF JUVENILE JUSTICE SECURE CARE FACILITIES 4 (2008).

[8] *See* Youngberg v. Romeo, 457 U.S. 307, 317 (1982); Henry A. v. Willden, 678 F.3d 991, 1000 (9th Cir. 2012); Norfleet v. Arkansas Dep't of Human Servs., 989 F.2d 289, 292 (8th Cir. 1993); Yvonne L. v. New Mexico Dep't of Human Servs., 959 F.2d 883, 891 (10th Cir. 1992); Charlie H. v. Whitman, 83 F. Supp. 2d 476, 505 (D.N.J. 2000).

[9] *See* Leslie et al., *supra* note 6; *see also* CLOYES ET AL., *supra* note 6, at 63-68; *AACAP Position Statement on Oversight of Psychotropic Medication Use for Children in State Custody: A Best Principles Guideline*, AMERICAN ACAD. OF CHILD AND ADOLESCENT PSYCHIATRISTS, http://www.aacap.org/App_Themes/AACAP/docs/member_resources/practice_information/foster_care/FosterCare_BestPrinciples_FINAL.pdf (last visited Feb. 17, 2015) [hereinafter *AACAP*]; *Resolution Regarding Judicial Oversight of Psychotropic Medications for Children Under Court Jurisdiction*, NATIONAL COUNCIL OF JUVENILE AND FAMILY COURT JUDGES, http://www.ncjfcj.org/sites/default/files/Fnl_PsychMedsResolution_071313.pdf (last visited Feb. 17, 2015) [hereinafter *Resolution*].

[10] Solchany, *supra* note 5.

Section I provides information about most commonly prescribed psychotropic medications to foster children, the prescription rates, the side effects of psychotropic medications, and testimonials from foster children who have been over-medicated. Section II presents information about the position statement of the AACAP's Best Principles Guideline and the NCJFCJ's 2013 Psychotropic Medication Oversight Resolution. Section III discusses the state and agency responses to date across the country and explains the need for a coordinated, comprehensive set of policies and data collection in order to protect children and to ensure that children and youth in state custody receive all modes of treatment to successfully manage their conditions or symptoms. Section IV asserts the need for attorneys and judges to improve their competence on legal issues around use of psychotropic medication.

I. "I Feel Like a Zombie": The Over-Administration of Psychotropic Medications to Children in State Custody Is a Nationwide Epidemic

A. What are psychotropic medications?

Psychotropic medications are defined as "substances that act directly on the brain to chemically alter mood, cognition, or behavior."[11] Their effect is typically achieved by altering the process of the brain's neurotransmission.[12] Psychotropic medications are typically divided into six classes: stimulants, antidepressants, depressants, antipsychotics, mood stabilizers, and anxyiolitics (anti-anxiety).[13]

Of all the psychotropic medications, antipsychotics are, by far, the most frequently prescribed medicines to foster children and youth involved in the juvenile justice system.[14] Antipsychotics were initially designed to treat schizophrenia and bipolar disorder in adults, but are commonly prescribed to these children to treat behavioral issues for which the FDA has not approved, including agitation, anxiety, acting out, and irritability.[15] The most commonly prescribed antipsychotics, which are also among the most powerful medications, include Seroquel, Abilify, Risperdal, Zyprexa, Geodon, Invega, Latuda, Fanapt, Clozaril, Saphris, and Solian.[16] Only Seroquel, Abilify, Risperdal, and Zyprexa have very limited FDA-approval for use in children.[17]

B. What are the prescription rates among foster children and youth involved in the juvenile justice system?

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[11] 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, 466 (2010).
[12] *Id.*
[13] Matthew M. Cummings, *Sedating Forgotten Children: How Unnecessary Psychotropic Medication Endangers Foster Children's Rights and Health*, 32 B.C. J.L. & SOC. JUST. 357, 359 (2012).
[14] Michael Piraino, *Another Prescription Drug Abuse Problem: The Overmedication of Foster Kids*, THE HUFFINGTON POST (May 5, 2011), http://www.huffingtonpost.com/michael-piraino/prescription-drug-abuse_b_855547.html; *see also* CLOYES ET AL., *supra* note 6, at 8.
[15] Abdelmalek et al., *supra* note 3.
[16] *Id.*
[17] *Id.*

Foster children and youth involved in the juvenile justice system are prescribed psychotropic medications at shockingly high rates. At a nation-wide level, studies have shown that up to fifty percent of all children in foster care are prescribed one or more of these psychotropic medications at any given time, a rate nine times higher than children not in foster care.[18] While published national data on the rates of psychotropic medication use in either detained or incarcerated juvenile populations does not currently exist, recent studies conducted in various states indicate that these youth are also prescribed psychotropic medications at rates higher than youth in the general population.[19] A study of the Utah Juvenile Justice System indicated that fifty-six percent of youth involved in the juvenile justice system were prescribed psychotropic medications.[20] A study of the Washington State Juvenile Justice System indicated that thirty-six percent of youth involved in the juvenile justice system were prescribed psychotropic medications.[21] And, a study of the Oregon State Juvenile Justice System indicated that fifty-eight percent of females and thirty-two percent of males involved in the juvenile justice system were prescribed psychotropic medications.[22]

As previously discussed, the most commonly prescribed psychotropic medications to foster children and youth involved in the juvenile justice system are antipsychotics. Foster children are given antipsychotics at a rate nine times higher than children not in foster care, according to a 2010 sixteen state analysis by Rutgers University.[23] An estimated fifty percent of youth under eighteen who are within the juvenile justice system are prescribed antipsychotics, compared to just eight to ten percent in the general population.[24] Additionally, a 2007 study of the Florida Department of Juvenile Justice indicated that in twenty-four months, the Department of Juvenile Justice purchased 326,081 tablets of antipsychotic medications for use in state-operated jails – enough to hand out 446 pills a day, seven days a week, for two years in a row to the 2,300 youth involved in the Florida juvenile justice system.[25]

Not only are foster children and youth involved in the juvenile justice system prescribed psychotropic medications – the majority of which are antipsychotics – at rates that are truly

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[18] *See* Camp, *supra* note 2, at 373; *see also Prescription Psychotropic Drug Use Among Children in Foster Care: Hearing Before the Subcomm. on Income Sec. and Family Support of the H. Comm. on Ways and Means*, 110th Cong. 11 (2008), *available at* http://www.gpo.gov/fdsys/pkg/CHRG-110hhrg45553/html/CHRG-110hhrg45553.htm (citing the testimony of Laurel K. Leslie, M.D., in which she stated that the research studies available show rates of psychotropic drug medication use ranging from 13-50% among children in foster care and the testimony of Tricia Lea, Ph.D., in which she stated that that in 2003, twenty-five percent of children in Tennessee foster care were prescribed psychotropic drugs); Melissa D. Carter, *Medicating Trauma: Improving Prescription Oversight of Children in Foster Care*, 46 CLEARINGHOUSE REV. 398, 399 (2013).

[19] *See* Lyons et al., *supra* note 2, at 59; *see also* Alison Evans Cuellar et al., *Incarceration and Psychotropic Drug Use by Youth*, 163 PEDIATRIC ADOLESCENT MED. 219 (2008).

[20] S*ee* CLOYES ET AL., *supra* note 7, at 8.

[21] *See* Lyons et al., *supra* note 2, at 59.

[22] *Id.*

[23] Abdelmalek et al., *supra* note 3.

[24] Ashley A. Norton, *The Captive Mind: Antipsychotics as Chemical Restraint in Juvenile Detention*, 29 J. CONTEMP. HEALTH L. & POL'Y 152, 162-63 (2012).

[25] Mai Szalavitz, *Drugging the Vulnerable: Atypical Antipsychotics in Children and the Elderly*, TIME, May 26, 2011, http://healthland.time.com/2011/05/26/why-children-and-the-elderly-are-so-drugged-up-on-antipsychotics/.

disturbing, but they are also heavily over-medicated.[26] Over-medication of foster children and youth involved in the juvenile justice system is not the only alarming trend in psychotropic medication prescription rates.[27] Even more frightening is polypharmacy, which occurs when a child is prescribed psychotropic medications concomitantly, or in combination.[28] These children are often prescribed a deadly combination of the most powerful psychotropic medications, despite the fact that experts state that children should rarely take multiple psychotropic medications at the same time.[29]

A recent study of forty-seven states and the District of Columbia indicated that 38.3 percent of states were administering multiple psychotropic medications simultaneously to foster children and 21.3 percent of states were engaging in polypharmacy before monopharmacy.[30] Additionally, a recent United States Government Accountability Office ("GAO") study of 100,000 foster children across five states found that, in Texas, foster children were fifty-three times more likely to be prescribed five or more psychotropic medications at the same time than non-foster care children.[31] And, a recent study of the Utah Juvenile Justice system indicated that sixty-two percent of the youth prescribed psychotropic medications were taking more than one medication concomitantly, while thirty-eight percent were only taking one psychotropic medication.[32] GAO experts stated, upon review of these findings, that they did not find any evidence supporting the use of five or more psychotropic medications in adults, let alone in children.[33]

C. What effects do psychotropic medications have on children?

Psychotropic medications have a number of extreme side effects on children.[34] Side effects include tics, increased heart rate and blood pressure, vomiting, increased appetite and weight gain, sleepiness, sedation, stomachaches, dizziness, diarrhea, tremor, hair loss, unusual bleeding or bruising, rash or hives with itching, and suicidal thoughts and attempts.[35] Other side effects include akathisia (motor restlessness, desire to remain in constant motion), acute dystonia (spasms of upper body, face, tongue and eyes), neuroleptic malignant syndrome (rare but potentially fatal, it is characterized by muscular rigidity and altered consciousness), tardive dyskinesia (involuntary movements of various body parts, which can be irreversible), and an increased risk of diabetes.[36] In 2004, a Columbia University review of the pediatric trials of

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[26] *See* Burton, *supra* note 11, at 477; *see also* U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-12-270T, FOSTER CHILDREN: HHS GUIDANCE COULD HELP STATES IMPROVE OVERSIGHT OF PSYCHOTROPIC PRESCRIPTIONS (2011).
[27] *See* Camp, *supra* note 2, at 378; Daniel J. Safer et al., *Concomitant Psychotropic Medication for Youths*, 160 AM. J. PSYCHIATRY 3, 438-39 (2003).
[28] Carter, *supra* note 18, at 399.
[29] *Id.*
[30] Leslie et al., *supra* note 7. Monopharmacy means the use of a single medication, as opposed to polypharmacy, which is the use of multiple medications. *Id.*
[31] U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 26.
[32] S*ee* CLOYES ET AL., *supra* note 7, at 7-8.
[33] U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 26.
[34] Norton, *supra* note 24, at 159; *see also* Citizens Comm'n on Human Rights Int'l, *supra* note 6.
[35] Norton, *supra* note 24, at 160.
[36] *Id*; *see also* David M. Rubin, *Risk of Incident Diabetes Mellitus Following Initiation of Second-Generation Antipsychotics Among Medicaid-Enrolled Youths*, 169 JAMA PEDIATRICS (2015).

commonly prescribed psychotropic medications found that young people who took them often experienced suicidal thoughts or actions.[37] And in 2006, results of an analysis of FDA data showed that at least forty-five children died between 2000 and 2004 from the side effects of psychotropic medications.[38]

Throughout various interviews of foster children and youth involved in the juvenile justice system, children report that they were heavily over-medicated while in state custody. These children have stated that psychotropic medications make them "feel like zombies."[39] For example:

- Eleven-year-old Ke'onte from Texas indicated that he was on at least twelve different psychotropic medications while in foster care, up to four of them concomitantly.[40] The medications made him irritable and exhausted, caused a loss of appetite, and put him "in a lights-out mode fifteen minutes" after he had taken them.[41]
- Fourteen-year-old Westley stated that he was prescribed five psychotropic medications concomitantly.[42] He would resist the pills because he did not like the way they made him feel.[43]
- Mark, a former foster child from California, was also prescribed multiple psychotropic medications concomitantly.[44] He stated that he felt too "zoned out" to focus on high school and was so groggy that he was cut from his varsity basketball team.[45]
- Yolanda, a former foster child who was also involved in the California juvenile justice system, indicated that doctors prescribed her a series of powerful psychotropic medications in order to numb her pain from being physically and sexually abused and control her outbursts.[46] She was "so medicated with psychotropic medications that she literally lost her ability to speak."[47]

Unfortunately, these stories are not unique to Ke'onte, Westley, Mark and Yolanda. All across the United States, foster children and youth involved in the juvenile justice system are prescribed multiple powerful psychotropic medications at significantly higher rates than children in the general population. These children remain heavily over-medicated – those who prescribe

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[37] Norton, *supra* note 24, at 160.
[38] Citizens Comm'n on Human Rights Int'l, *supra* note 6.
[39] *See Freed*, *supra* note 5.
[40] Abdelmalek et al., *supra* note 3.
[41] Jenny Gold, *Foster Kids Given Psychiatric Drugs at Higher Rates*, NPR.COM (Dec. 1, 2011), http://www.npr.org/blogs/health/2011/12/01/143017520/foster-kids-even-infants-more-likely-to-be-given-psychotropic-drugs.
[42] *See Freed*, *supra* note 5.
[43] *Id.*
[44] Karen De Sea, *Drugging our Kids: Bay Area News Group Investigation*, MERCURY NEWS (Aug. 24, 2014), http://webspecial.mercurynews.com/druggedkids/?page=pt1.
[45] *Id.*
[46] *Id.*
[47] *Id.*

these medications use them "like candy" – and the overreliance on these medications is a nationwide epidemic.[48]

D. What problems in the psychotropic medication oversight and regulation process have foster children and youth involved in the juvenile justice system encountered?

Polypharmacy is not the only problem related to prescription drugs that foster children and youth involved in the juvenile justice system encounter while in the care of the state. First, many states prescribe psychotropic medication to foster children and youth involved in the juvenile justice system without the informed consent of the child, his/her parent, or court-appointed guardian.[49] In the majority of states, the state often provides consent on behalf of the child, although sound reasons, discussed in Section II.A, recommend against this process.[50] Second, many states prescribe psychotropic medication without completion of a full medical history and/or making any diagnostic assessment, without record keeping by the agency who has custody of the child, without protocols to monitor and review medication use on a short or long-term basis, and with inadequate court oversight.[51] These states fail to properly document the administration of psychotropic medications or to conduct periodic reviews of a medication plan.[52] Third, many states prescribe psychotropic medication to control behavior, in dosages exceeding the maximum recommendation, and for off-label use.[53] Foster children and youth involved in the juvenile justice system are often prescribed these medications simply for the purpose of sedating the child – basically, maintaining control – a practice which has been widely condemned.[54] Lastly, many states prescribe psychotropic medication without any previous or concurrent use of alternate therapies or psychosocial treatments.[55]

II. AACAP and NCJFCJ: Best Principles Guideline and Recommendations to Improve the Administration and Oversight of Psychotropic Medications

As a result of the various problems foster children and youth involved in the juvenile justice system have faced, the AACAP and the NCJFCJ made recommendations to improve use of psychotropic medications for children in the child welfare and juvenile justice system.[56]

A. No psychotropic medication should be prescribed without informed consent by the child, his/her parent, guardian and/or licensed caretaker.

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[48] *See* Burton, *supra* note 11, at 477; *see also* U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 26.
[49] *Id.* at 380; *see also* Joseph V. Penn et al., *Practice Parameter for the Assessment and Treatment of Youth in Juvenile Detention and Correctional Facilities*, 44 J. AM. ACAD. CHILD ADOLESCENT PSYCHIATRY 1085, 1094-95 (2005).
[50] *See* Camp, *supra* note 2, at 380; *see also* Leslie et al., *supra* note 7 (discussing that a state should not be equated with a parent for the purpose of medicating a child since the state does not form an emotional attachment with the child).
[51] *See* Leslie et al., *supra* note 7; *see also* Penn et al., *supra* note 49, at 1094-95.
[52] *See* Leslie et al., *supra* note 7; *see also* Penn et al., *supra* note 49, at 1094-95.
[53] *See* U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 26; Leslie et al., *supra* note 7.
[54] *See* Leslie et al., *supra* note 7; *see also* Camp, *supra* note 2, at 373; Penn et al., *supra* note 49, at 1094.
[55] *See* Penn et al., *supra* note 49, at 1095-96.
[56] *See AACAP*, *supra* note 9; *see also Resolution*, *supra* note 8.

As stated, in many states, the state agency often provides consent for the administration of psychotropic medications on behalf of the child-patient.[57] The AACAP has recommended against this practice, particularly because a state agency should not be equated with a parent for the purpose of medicating a child since the state does not form an emotional attachment with the child.[58] While in state custody, the child interacts with a long series of social workers, clinic doctors, caseworkers, and supervisors making it impossible for the agency to form a bond with the child.[59] The state is less likely to make sound medical decisions for the child because it does not know the intricacies of the child's medical or behavioral history.[60]

According to the Best Principles Guideline, states should not permit a state agency to consent to the administration of psychotropic medications on behalf of a child.[61] The AACAP recommends that states should identify the parties empowered to consent for treatment for youth in state custody in a timely fashion and establish a mechanism to obtain consent for psychotropic medication management from minors when possible.[62] Because studies have indicated that fourteen-year-olds possess the developmental capabilities necessary for providing informed consent to personal health and medical treatment, child development psychologists and the AACAP recommend that children fourteen years of age or older provide informed consent on behalf of themselves.[63] For children under fourteen years of age, informed consent should be obtained by the parent, guardian, or licensed caregiver.[64]

States should obtain and distribute simply written psychoeducational materials and medication information sheets to facilitate the consent process.[65] Both the AACAP and NCJFCJ have recommended that these materials consist of information about the proposed medication, and its risks and potential side effects, including adverse effects of sudden discontinuation of psychotropic medications.[66]

B. No psychotropic medication should be prescribed without appropriate administration, oversight, and regulation.

The AACAP makes several recommendations to improve the oversight and

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[57] *See* Leslie et al., *supra* note 7; *see also* Michael W. Naylor et al., *Psychotropic Medication Management for Youth in State Care: Consent, Oversight and Policy Considerations*, 86 CHILD WELFARE 175, 182 (2007).
[58] *See AACAP*, *supra* note 9; *see also* Leslie et al., *supra* note 7; Bernard P. Perlmutter & Carolyn S. Salisbury, *"Please Let Me Be Heard:" The Right of a Florida Foster Child to Due Process Prior to Being Committed to a Long-Term, Locked Psychiatric Institution*, 25 NOVA L. REV. 725, 734 (2001).
[59] Perlmutter & Salisbury, *supra* note 58, at 734.
[60] *Id; see also* GARY B. MELTON, ET AL., NO PLACE TO GO: THE CIVIL COMMITMENT OF MINORS 157-58 (1998).
[61] *AACAP*, *supra* note 9; *Resolution*, *supra* note 9.
[62] *AACAP*, *supra* note 9; *Resolution*, *supra* note 9; Penn et al., *supra* note 49, at 1094-95.
[63] Lois A. Weithorn & Susan B. Campbell, *The Competency of Children and Adolescents to Make Informed Treatment Decisions*, 53 CHILD. DEV. 1589, 1589 (1982); *AACAP*, *supra* note 9.
[64] *AACAP*, *supra* note 9.
[65] *Id.*
[66] *AACAP*, *supra* note 9; *Resolution*, *supra* note 9.

regulation of psychotropic medication use in foster children and youth involved in the juvenile justice system.[67] Its Best Principles Guideline notes that developing both a short-term and long-term monitoring plan is essential for assessing any developments or increases in suicidal ideation, initial side effects, and potential changes over time.[68] Thus, the guidelines recommend that the prescriber reassess the child frequently in order to monitor the response to the treatment and ensure the medication's effectiveness.[69] At a minimum, periodic reviews of the child should occur every six months.[70]

Additionally, psychotropic medications are often prescribed without the presence of a full medical history and diagnostic assessment.[71] Each state should require its agencies to maintain an ongoing record of diagnoses, height and weight, allergies, medical history, ongoing medical problem list, psychotropic medications, and adverse medication reactions that are easily available to treating clinicians 24 hours a day.[72]

C. No psychotropic medication should be prescribed to a child without secondary review in dosages that exceed recommended use, or for off-label or concomitant use.

Many states prescribe psychotropic medications to foster children and youth involved in the juvenile justice system concomitantly, or in combination.[73] Additionally, these states often prescribe psychotropic medications to manage – not treat – these children.[74] This is referred to using the medication as a "chemical restraint," since the medication is being used without a therapeutic purpose, but for the sole purpose of sedating and immobilizing the child.[75] Concomitant use and chemical restraint of these children has been widely condemned by the AACAP and the Child Welfare League.[76]

In addition, many prescriptions are written for psychotropic medications in dosages exceeding current manufacturer, federal, professional and internal state maximum recommendations.[77] Taking psychotropic medications at dosages exceeding recommended levels not only increases the potential for adverse side effects, and for some medications, a higher dose may actually be less effective than the more moderate recommended dose.[78] As a result, the AACAP recommends that psychotropic medications only be administered at

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[67] Solchany, *supra* note 5; *AACAP*, *supra* note 9; *Resolution*, *supra* note 9.
[68] *See* Magellan Health, *Appropriate Use of Psychotropic Drugs in Children and Adolescents* MAGELLAN HEALTH (2013), *available at* *http://www.magellanprovider.com/MHS/MGL/providing_care/clinical_guidelines/clin_monographs/psychotropicdrugsinkids.pdf*; *see also* Solchany, *supra* note 5; *AACAP*, *supra* note 9; Penn et al., *supra* note 49, at 1094.
[69] Magellan Health, *supra* note 68; Solchany, *supra* note 5; *AACAP*, *supra* note 9.
[70] Magellan Health, *supra* note 68.
[71] *See* Leslie et al., *supra* note 7.
[72] *AACAP*, *supra* note 9.
[73] Carter, *supra* note 18, at 399.
[74] Camp, *supra* note 2, at 378.
[75] *See* Burton, *supra* note 11, at 492.
[76] *Id.*
[77] Leslie et al., *supra* note 7.
[78] U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 26.

therapeutic dosages and should not exceed recommended dosage levels.[79]

D. Use of alternative therapies must precede or accompany use of psychotropic medications in children and youth in custody.

According to a 2006 report issued by the FDA, the FDA approved only thirty-one percent of psychotropic medications for children and youth.[80] Because pediatric trials of commonly prescribed psychotropic medications found that children/youth who took them experienced suicidal thoughts or action, the FDA ordered pharmaceutical companies to add a "black box warning" to all commonly prescribed psychotropic medications due to the medications' effect on children under 18.[81] A "black box warning" appears on a prescription drug's label and is designed to call attention to serious or life-threatening risks.[82] Despite FDA warnings, use of psychotropic medications in children continues without first exploring alternative treatment options, either before turning to these medications or as a part of the medication treatment regimen.[83]

The AACAP guidelines dictate that children and youth should only take psychotropic medication when absolutely necessary and as a last resort.[84] The guidelines insist that prior to prescribing psychotropic medications to a child or youth, other therapies should be utilized to treat the child, such as intensive therapy or psychosocial treatments.[85]

III. States Should Adopt Comprehensive Policies on Administration and Oversight of Psychotropic Medication in Collaboration with Medical Expertise

This resolution urges states and its administrative agencies that oversee child welfare cases and juvenile justice systems to develop comprehensive policies to protect children in state custody from over-medication. It also urges juvenile and dependency courts to implement administration and oversight protocols in order to manage and regulate psychotropic medication use among children in foster care and youth involved in the juvenile justice system.[86] Finally, the resolution urges attorneys and judges to become educated and offer training about the use of psychotropic medication in children.

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[79] U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 26; Solchany, *supra* note 5; Leslie et al., *supra* note 7.
[80] Cummings, *supra* note 13, at 360.
[81] *See* Citizens Comm'n on Human Rights Int'l, *supra* note 6.
[82] U.S. Food & Drug Administration, *A Guide to Drug Safety Terms at the FDA*, FDA (Nov. 2012), http://www.fda.gov/downloads/ForConsumers/ConsumerUpdates/ucm107976.pdf.
[83] Leslie et al., *supra* note 7.
[84] Cummings, *supra* note 13, at 361.
[85] Solchany, *supra* note 5; *AACAP*, *supra* note 9; *Resolution*, *supra* note 9.
[86] Congress' power to require states to implement psychotropic drug administration and oversight protocols is originated from tying the requirements to federal funding. *See* The Am. Acad. of Pediatrics, *Health and the Fostering Connections Act of 2008*, FOSTERINGCONNECTIONS.ORG (Feb. 2013), *available at* http://www.childrensdefense.org/child-research-data-publications/data/state-data-repository/perspectives-on-fostering.pdf. If Congress tied this legislation to the health care provision of the Fostering Connections Act, states would be incentivized to immediately comply because they would receive federal funding for doing so. *Id.*; *see also* Camp, *supra* note 2, at 395.

In a recent analysis of the policies and practices of forty-seven states and the District of Columbia by the Tufts Institute, twenty-six states currently have some policies and/or guidelines regarding psychotropic medication use in children involved in state custody.[87] Thirteen states are in the process of developing a guideline, and nine states have no policy or guideline regarding psychotropic medication use.[88]

Many of the policies implemented in the 26 states are spotty and do not follow the AACAP guidelines. While these states are moving in the right direction, the vast majority of states are still over-medicating these vulnerable populations by engaging in unregulated, unsupervised and improper prescription processes.

A. Minimal use of informed consent by states

In the twenty-six states that did have a written policy or guideline regarding psychotropic medication use, only two states included the state-involved child in the informed decision making process.[89] These two states acknowledge that states' informed consent processes needs to be strengthened in order to protect youth from being overmedicated.[90] The states, however, provide youth with information about the proposed medication, its side effects and medical risks.[91] In twenty-two states, informed consent authority resides with the child welfare agency, despite the fact that the AACAP has strongly recommended against this practice.[92]

In thirteen states currently developing policy, all expressed interest in involving the child, when age-appropriate, in the decision-making process.[93] These states recognized the importance of a "child-centered perspective"[94] and are working toward implementing a comprehensive child welfare psychotropic medication oversight system.[95] Their system would include obtaining informed consent from the youth if psychotropic medication is recommended, [96] and actively involve the youth in both initial and ongoing decision-making.[97]

Finally, nine states have no written policy or guidelines regarding informed consent in the psychotropic medication administration process.[98]

B. Administration, Oversight, and Regulation are Lacking

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[87] *See* Leslie et al., *supra* note 7. "States" refers to either child welfare agencies or state legislation. *Id.*
[88] *See* Leslie et al., *supra* note 7.
[89] *Id*.
[90] *Id*.
[91] *Id.*; *see also* Naylor et al., *supra* note 57, at 182.
[92] Leslie et al., *supra* note 7; *AACAP*, *supra* note 10.
[93] Leslie et al., *supra* note 7 (finding that states wanted to involve youth, when age-appropriate, in decisions about the child and that the name of the medication, dosage, why it's being prescribed, side effects, and risks should be provided to the child all in language the child can understand).
[94] A "child-centered perspective" is all about focusing on a child's needs and best interests directly from the perspective of the child. *See* Barbara Bennett Woodhouse, *From Property to Personhood: A Child-Centered Perspective on Parents' Rights*, 5 GEO. J. ON FIGHTING POVERTY 313, 318 (1997).
[95] Leslie et al., *supra* note 7.
[96] *Id.*
[97] *Id.*
[98] *Id.*

Among the 26 states that have instituted some policy around psychotropic medication use in state-involved children and youth, all of the states identified "monitoring a youth's response to psychotropic medication and its side effects" as a major challenge.[99] While these states recognized that this was an important aspect in medication oversight, they did not *require* periodic reporting and review of the benefits and side effects of medications.[100] Only North Carolina requires a physician to review the psychotropic medication regimen of a state-involved child at least every six months.[101]

In the thirteen states that were currently in the process of developing a guideline, all thirteen expressed interest in ensuring that up-to-date oversight programs and records on each child-patient were in place.[102] Nine states had no written policy or guidelines regarding the oversight and regulation of the psychotropic medication administration process.[103]

C. Dosages, Polypharmacy, and Off-Label Use Needs Scrutiny; Alternate Treatments and Therapies are Ignored

Of the forty-eight states that participated in this study, fourteen states were administering psychotropic medications to state-involved children in dosages exceeding current maximum recommendations.[104] Eight states were administering newer, non-FDA approved psychotropic medications over FDA-approved medications. Eighteen states were administering three to five psychotropic medications to state-involved children simultaneously, despite the fact that GAO experts stated that they did not find *any* evidence supporting the use of five psychotropic medications in adults, let alone children.[105] And eight states were prescribing psychotropic medications used to treat Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, or Adjustment Reaction Disorder to state-involved children that did not exhibit symptoms of any of those disorders.[106]

All forty-eight states in the study understand that psychotropic medication plays an important role in addressing mental health problems.[107] However, all of the states were concerned that medications were being used to manage problems that might respond as well, or better, to psychosocial treatments.[108] It is unclear from this study the percentage of states that consider

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[99] *See id.*
[100] *See id*; *see also* Karen de Sa, *California Creates First Guidelines for Prescribing Psych Meds to Foster Youth*, BAYAREANEWS (Apr. 11, 2015), http://www.insidebayarea.com/breaking-news/ci_27891659/california-creates-first-guidelines-prescribing-psych-meds-foster (discussing the fact that although states must regularly report on medication use in order to ensure children are being prescribed safely, Washington, Wyoming, New Jersey and Illinois are moving in the right direction by requiring that children prescribed psychotropic medications receive second medical opinions).
[101] *See* Naylor et al., *supra* note 57, at 185.
[102] *See* Leslie et al., *supra* note 7.
[103] *Id.*
[104] *Id.*
[105] *Id.*; U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 26.
[106] *Id.*
[107] *Id.*
[108] *Id.*

alternative therapies prior to prescribing psychotropic medications, but because all of the states indicated it as a major area of concern, it is unlikely that alternative treatment options are being explored.[109]

D. Data Should be Collected in Both Systems for Appropriate Oversight

Published national data on the rates of psychotropic medication use in either detained or incarcerated juvenile populations does not currently exist.[110] Data on the rates of psychotropic medication use among children and youth in foster care are spotty and difficult to locate. A brief on the latter subject by ACF states, "Prior research on psychotropic medication use has relied primarily on Medicaid data, which does not permit examination of medication use in relationship to mental health needs and typically does not distinguish children in foster care by type of foster care placement. Children eligible for Medicaid living in foster care may be living formally with kin caregivers, in group homes or residential placements, or in more traditional nonrelative, foster parent homes. These various types of foster care placements may be associated with different rates of psychotropic medication use or various levels of mental health need. Prior research also does not provide estimates of psychotropic medication use among children who remain at home with at least one biological parent after reports of maltreatment, or children living in informal kin caregiver arrangements."[111]

The GAO report recommended states improve documentation on the implementation of psychotropic medication policies and practices in the child welfare system, especially to confirm the use of alternative evidence-based therapies.[112] In addition, the Annie E. Casey Foundation, in a partnership with the Center for Health Care Strategies, specifically urges that, in order to limit overuse of psychotropic medication for children in foster care, data should be aggregated across systems for a comprehensive picture of use. Data, which often resides in disparate agencies, are needed for several purposes: to determine baseline rates of psychotropic medication use and expense; to identify outlier prescribing patterns; understand the types, number, and quantity of psychotropic medications prescribed; and track quality and cost outcomes. According to CSCG, New Jersey is examining child welfare, Medicaid, and children's behavioral health data to develop a clear picture of both psychotropic medication use and that of psychosocial interventions. The state is also enhancing its child welfare data information system to capture data on psychotropic medication use.[113]

Collection of data on the use of psychotropic medication and psychosocial treatments and therapies in the juvenile justice system in every state, territorial and tribal government is essential to understanding the areas of improvement that must be addressed. Likewise, uniform

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[109] *Id.*

[110] *See* Lyons et al., *supra* note 2, at 59.

[111] *Psychotropic Medication Use by Children in Child Welfare*, 17 NAT'L SURVEY OF CHILD & ADOLESCENT WELL-BEING 1 (2012).

[112] U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 26.

[113] Kamala Allen, *Reducing Inappropriate Psychotropic Prescribing For Children And Youth In Foster Care,* HEALTH AFFAIR BLOG (Apr. 17, 2015), http://healthaffairs.org/blog/2015/04/17/reducing-inappropriate-psychotropic-prescribing-for-children-and-youth-in-foster-care/

and consistent tracking of data in the child welfare system is necessary in order to create better oversight and implementation of policies to benefit the health and wellbeing of the children in their care. Congress should enact legislation requiring data collection in both systems.[114]

III. Attorneys and Judges Need More Education on Psychotropic Medications

Attorneys and judges in both the child welfare and juvenile justice systems have long accepted medications and the amount of medication for the children and youth in their cases as normal, expected, and medically necessary. However, the overuse of psychotropic medication among children and youth in state custody demands that lawyers for children and the courts ask many questions about the child's diagnosis, recommended treatment and alternatives, and the qualifications of the medical professionals prescribing and administering psychotropic medication. Lawyers for children and youth, as well as the courts that have jurisdiction over the cases, should ask, at a minimum, "Why is this prescribed? Why is this amount necessary? Where can I learn more about this medication and its side effects? What are the possible long term consequences of use of this medication? "[115] Moreover, to ensure continued competence and adherence to best practice standards and the rules of professional responsibility, attorneys and judges should be educated and develop technical knowledge on legal issues relating to psychotropic medications and on the appropriate use of psychotropic medication for children.[116]

Conclusion

Children in foster care and youth involved in the juvenile justice system are overmedicated as a result of the absence of meaningful policies to treat children with trauma and mental health conditions. Children, their parents, guardians or caregivers are not given informed consent before these powerful medications are prescribed. The prescriptions are written without the benefit of a complete medical history and a diagnostic assessment. Protocols do not exist to monitor the side effects of these medications and to adjust medications on an ongoing basis. Off-label use is widespread, often by medical professionals without sufficient training, dosages

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[114] Marian Wright Edelman, *Child Watch Column: Overmedicating Children in Foster Care,* CHILDREN'S DEFENSE FUND (May 22, 2015), http://www.childrensdefense.org/newsroom/child-watch-columns/child-watch-documents/OvermedicatingChildrenInFosterCare.html (bringing attention to the Administration's current budget proposal that requests $250 million to reduce the over-reliance on drugs and increase the use of appropriate screening, assessment, and interventions, including better data collection and information sharing by child welfare agencies, Medicaid, and behavioral health services).

[115] Solchany, *supra* note 5, 27-28.

[116] *NACC Recommendations for Representation of Children in Abuse and Neglect Cases*, NAT'L ASSOC. OF COUNSEL FOR CHILDREN, http://swrtc.nmsu.edu/files/2014/12/NACC-Standards-and-Recommendations.pdf (last visited May 27, 2015) (stating that competence is the foundation of all legal representation. For attorneys who represent children and youth, competence includes knowledge of child development, and of trauma and mental health conditions, and treatment and services available to the child. An attorney must have sufficient knowledge to advocate for all of a child's needs, including their medical and mental health needs, and the court has an ongoing role to ensure that lawyers are continually trained); see also MODEL CODE OF PROF'L CONDUCT 1.1, 1.14(a) (1983); MODEL CODE OF PROF'L RESPONSIBILITY EC 7-1, EC 7-12, DR 6-10 (1980); AMERICAN BAR ASSOCIATION (1996); STANDARDS FOR PRACTICE FOR LAWYERS WHO REPRESENT CHILREN IN ABUSE & NEGLECT CASES §§ A-1, B-1, C-1 (1996); STANDARDS RELATING TO COUNSEL FOR PRVIATE PARTIES §§ 1.7, 4.3, 6.4, 9.2, 10.1 (1996); STANDARDS FOR PRACTICE FOR LAWYERS REPRESENTING CHILD WELFARE AGENCIES §§ C-2, D-2 (2004).

often exceed manufacturer recommendations, and concomitant use of multiple psychotropic medications is the norm. There is little oversight in the legal system by the courts or by the advocates who are appointed to represent the best interest of children, and children and youth are rarely given the opportunity to give their opinions about their health care and the medications they are taking. It is easier to prescribe psychotropic medications in lieu of alternate treatments or therapies, when the latter should always be used first or as a concurrent treatment with medication.[117] All states should develop policies incorporating the recommendations set forth in this resolution so that foster children and youth involved in the juvenile justice system have the best opportunity for meaningful, appropriate and comprehensive mental health treatment.

Respectfully submitted,
Vanessa Peterson Williams, Chair
Commission on Youth at Risk
May 201

[117] *See* Leslie et al., *supra* note 7; *see also* CLOYES ET AL., *supra* note 7, at 63-68.