Psychotropic medication use in foster children: An opportunity for psychiatric pharmacists

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The use of psychotropic medications in United States foster care children is an issue of growing concern among clinicians, child serving agencies, and legislators. Although pharmacologic interventions are accepted as part of multi-modal treatment strategies for many symptoms of mental illness, the relatively high use of psychotropic agents in this population, as well as the limited data on efficacy and both short and long-term adverse effect risks, have led to increased scrutiny. In addition to safety, issues of concern include indications for use, overdiagnosis, appropriate consent for treatment, oversight/monitoring of psychotropic prescribing and psychiatric consultation, and the availability of medication information for clinicians, foster parents, and care givers.

The available research examining psychotropic medication use in foster care children clearly show a rate of use in excess of the non-foster care population. A 2008 study of Medicaid-insured youth in six states found that foster care youth were prescribed psychotropic medication at rates 2.7 to 4.5 times higher than non-foster children.[1] Twenty-one to 39% of foster care youth received a prescription for psychotropic medications, compared to 5 to 10% in the general population.[1] Furthermore, the rate of use in children is increasing. Medicaid data from 47 states and the District of Columbia demonstrate an increase in the percentage of children receiving second generation antipsychotics from 2002 to 2007 in both the 6-11 year (7.9 to 10.1%) and 12-18 year (11.7 to 15.6%) age groups.[2]

New psychotropic agents and expanded indications for use can contribute to increases in prescribing. Certainly, children involved with the child welfare system have higher rates of socio-emotional, behavioral, and mental health challenges compared to those who are not in the system and circumstances leading to foster care placement may also affect utilization rates.[3]

In 2011, the Government Accountability Office (GAO) testified before the U.S. Congress regarding both specific prescribing practices and the need for greater state oversight of psychotropic medication use in foster care.[1] They identified three prescribing practices that they viewed as increasing the level of risk for children. These include concomitant use of five or more psychotropic medications, exceeding maximum dosage guidelines and prescribing to infants less than one year old.[1] Importantly, the GAO study determined that children in foster care face these three dangerous prescribing practices at higher rates than non-foster children. For example, Zito et al found that up to 41% of children in foster care who were prescribed psychotropic medications actually received three or more different psychotropic medications during the same month.[4] The systems issues identified by the GAO include:

- improving the consent process and training for those providing consent;
- establishing state guidelines for psychotropic medication use and ongoing monitoring of the use of these medications;
- providing appropriate consultation for those responsible for treatment and those responsible for consent particularly when concerns have been raised about a child's medication treatment;
- developing systems for sharing information with clinicians, foster parents, caregivers, case workers and those involved in the consent process.[1,5]

Over the past few years, the response to concerns regarding increasing use of psychotropic medications in foster care children has been varied and far reaching. Stirred by concern for vulnerable youth, economics, media attention and federal action, states have undertaken new initiatives to study, monitor and control psychotropic drug use in foster children and youth served by Medicaid. For example, North Carolina has developed the A+KIDS Registry to document off-label antipsychotic use in children less than 17 years.[6] Maryland has implemented the Peer Review Program for Mental Health Medications to provide consultation and prior authorization for antipsychotic use in children through

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age nine.[7] Texas has published "Psychotropic Utilization Parameters for Foster Children."[8] Illinois has established an independent medication review service to ensure the safety and effectiveness of psychotropic medications in children cared for by the state.[9]

Legislation has played an important role in the advancement, safety, and health of foster care youth. The Adoption and Safe Families Act of 1997 was the first federal legislation passed that addressed the mental health of this population.[10] However, the strong focus on permanent placement meant that health and safety were only important prior to placement and not long term.[11] The Fostering Connections to Success and Increasing Adoptions Act of 2008 addressed this weakness by requiring states "develop a health oversight plan to identify and respond to the health and mental health care needs of children in foster care."[12] The act further required that the plan include "oversight of prescription medicines." Two years after the enactment of the Fostering Connections to Success and Increasing Adoptions Act, research was conducted to evaluate state policies surrounding psychotropic medication use in foster care youth. Of 47 US states evaluated, only 26 had policies in place regarding psychotropic medication use in foster care. Thirteen states were in the process of developing a policy, and the remaining nine states had no policy.[13]

The Child and Family Services Improvement and Innovation Act of 2011 improved upon the previous legislation, detailing circumstances in which health care oversight must occur. This Act requires states develop "protocols for the appropriate use and monitoring of psychotropic medications." In addition, it requires states to create a monitoring and treatment plan for the emotional trauma foster care children may face resulting from maltreatment and removal from home.[14] The progression of the legislation shows that monitoring mental health, specifically psychotropic medication use, has become a priority in the United States.

The legislation and increased scrutiny of psychotropic medication in foster care children provide an opportunity for psychiatric clinical pharmacists to become involved. The American Association of Child and Adolescent Psychiatry (AACAP) calls for states and local jurisdictions to establish advisory committees that include clinical pharmacists to establish guidelines for the use and monitoring of psychotropic medications.[15] Pharmacists can become involved in enhanced medication use evaluation, drug utilization review or prior authorization programs for this population. Psychiatric pharmacists can also participate as consultants and case reviewers or as educators and providers of information, particularly to caregivers and those involved in the consent process.

An important logistical issue in the implementation of these programs is coordination among the numerous parties involved in medication use decisions in foster care children. Medicaid pharmacy programs usually pay for the medication and may run authorization programs. Prescribers may be unaware of guidelines and procedures or the exact legal status of a child. Child welfare agencies and foster parents may have little expertise in psychopharmacology. Pharmacists familiar with Medicaid prescription programs who have demonstrated consultative relationships with prescribers and expertise in psychiatry and patient/family/case worker education can play an essential role in developing and implementing these programs.

The extensive use of psychotropic medication in foster children and other youth served by Medicaid has profound implications for individual patients. However, in order to assure safe, effective and legal use of these medications, new systems of education, authorization and monitoring are being developed in many states and local jurisdictions. The challenge faced by these jurisdictions represents an additional opportunity for psychiatric pharmacists.

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