CARING FOR OUR KIDS: ARE WE OVERMEDICATING CHILDREN IN FOSTER CARE?

HEARING

BEFORE THE

SUBCOMMITTEE ON HUMAN RESOURCES

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

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CARING FOR OUR KIDS: ARE WE OVERMEDICATING CHILDREN IN FOSTER CARE?

THURSDAY, MAY 29, 2014

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HUMAN RESOURCES,
Washington, DC.

The subcommittee met, pursuant to call, at 2:30 p.m., in Room 1100, Longworth House Office Building, the Honorable Dave Reichert [chairman of the subcommittee] presiding.

[The advisory of the hearing follows:]

HEARING ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

Chairman Reichert Announces Hearing on Caring for Our Kids: Are We Overmedicating Children in Foster Care?

Washington, May 29, 2014

Congressman Dave Reichert (R–WA), Chairman of the Subcommittee on Human Resources of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on the use of psychotropic medications among children in foster care. **The hearing will take place at 2:00 p.m. on Thursday, May 29, 2014, in room 1100 of the Longworth House Office Building.**

In view of the limited time available to hear from witnesses, oral testimony at this hearing will be from invited witnesses only. Witnesses will include experts on the prescription and use of psychotropic drugs by children, and especially children in foster care. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

Recent reports have highlighted how children in foster care are prescribed psychotropic drugs at very high rates. According to data compiled by the Congressional Research Service, between 2008 and 2010, nearly one out of every four children in foster care was using a psychotropic medication on any given day—more than four times the rate among all children. A recent *Wall Street Journal* story and a multipart *Denver Post* series highlighted how youth in foster care may be prescribed these powerful, mind-altering drugs because they are misdiagnosed as having mental health disorders instead of being recognized as having problems stemming from the abuse and neglect they have experienced.

Congress has taken a number of steps in recent years designed to prevent the overuse of psychotropic drugs by children in foster care. The *Child and Family Services Improvement Act of 2006* (P.L. 109–288) required States to describe how they consult with doctors to assess the health and well-being of children in foster care and determine appropriate medical treatment for them. The *Fostering Connections to Success and Increasing Adoptions Act of 2008* (P.L. 110–351) required States to ensure children in foster care have access to health and mental health care services and develop strategies for overseeing drugs prescribed to them. Most recently, the *Child and Family Services Improvement and Innovation Act of 2011* (P.L. 112–34) added that States must develop protocols covering the use of psychotropic medication for children in foster care.

States have also taken positive steps to address concerns about the use of psychotropic medications by children in foster care. These efforts include reviewing new prescriptions before they are approved, monitoring existing prescriptions, and examining data on prescription rates among youth in foster care. For example, in Illinois, board certified child psychiatric consultants review all psychotropic medication requests. Connecticut has hired a Chief of Psychiatry to oversee medications for youth in foster care. Texas has a data system designed to ensure that psychotropic medications are prescribed within established guidelines.

In announcing the hearing, Chairman Reichert stated, **"Our future lies with our nation's children. For kids in foster care, we have an added responsibility to help them succeed, including helping them overcome the trauma they experienced before, and in some cases since, they left their home. Recent news reports have highlighted how powerful psychotropic drugs are prescribed at high rates to children in foster care, including by individuals who may misdiagnose the effects of trauma on these children as a mental health problem. I look forward to hearing from experts on this issue, learning what States are doing to ensure the proper use of these medications, and discussing how the Federal Government can better support efforts to**

provide youth in foster care with the help they need to become successful adults.

FOCUS OF THE HEARING:

This hearing will focus on what is known about the use of psychotropic medications by children in foster care, how States have implemented recent Federal laws designed to ensure such medications are used appropriately, and how the Federal Government can continue to work with States to improve the oversight of these medications to ensure youth in foster care receive appropriate help.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, http://waysandmeans.house.gov, select "Hearings." Select the hearing for which you would like to submit, and click on the link entitled, "Please click here to submit a statement or letter for the record." Once you have followed the online instructions, submit all requested information. Attach your submission as a Word document, in compliance with the formatting requirements listed below, **by June 12, 2014.** Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721 or (202) 225–3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone, and fax numbers of each witness.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available online at *http://waysandmeans.house.gov/*.

Chairman REICHERT. The committee will come to order. Welcome to today's hearing on this very important topic of whether youth in foster care are being prescribed medications, whether or

not they are being prescribed appropriately. We will hear from our witnesses that too often the answer is no.

We know from research that foster children are prescribed mind-altering psychotropic drugs at very high rates, far higher than other children. CRS found that between 2008 and 2010 nearly one out of every four children in foster care was overmedicated. That is more than four times the rate among children overall. In too many cases, government programs may be trying to medicate away the troubles that these youths have experienced that will remain with them for many years after the medications end.

Dawna Hovenier is a young woman who was recently in foster care in my home State of Washington. She was unnecessarily medicated with a number of mind-altering drugs and will explain how that helps no one, least of all the youth who need it the most, and Dr. Phil McGraw will second this assertion that one of the most critical reasons to address the problem of overmedication is to ensure children receive proper treatment and not just chemical straitjackets that keep them from acting out.

Congress has taken a number of steps in recent years to highlight this issue, and we expect States to continue focusing more attention on prevention as a result of these changes. Federal law passed in 2006, 2008, and 2011 sharpened the focus of States on medical needs of foster youth, including the need to develop protocols preventing the overprescribing of medications.

Illinois is a leading example, as we will hear from Dr. Michael Naylor, whose office reviews all medication requests for children in foster care in Illinois. This effort has prevented overmedication of children, likely saving taxpayers money, but more importantly resulting in better care for children. Other States, including Texas and Connecticut, have similar programs, and part of our task is to ensure that all States are taking the necessary steps and learning from each other's best practices.

Ultimately the best solution for children is to be in a permanent, loving home with parents who watch out for them each and every day. This subcommittee knows that, and has focused its efforts during the past year in getting more foster youth into those sort of permanent, loving homes. And H.R. 3205, the Promoting Adoption and Legal Guardianship for Children in Foster Care Act, which passed the House last year, incentivizes States to move more children, especially older children, into adoptive homes, and just last week the House passed H.R. 4058, the Preventing Sex Trafficking and Improving Opportunities for Youth in Foster Care Act, which requires States to more quickly move children out of foster care into permanent homes. I am hopeful that we will enact these bills this year. That will help more children move from foster care into loving homes, improving their lives in many ways, vastly decreasing the likelihood of using or needing psychotropic drugs.

We welcome all of our witnesses today, and we look forward to their testimony. I was meeting today with one of the foster youth out there in the audience, Courtney is out there. She and I had a chance to talk, and she told her story of moving from foster home to foster home to foster home and even living in a foster home that was not legally a foster home anymore, and State authorities didn't even know that it had been removed from the foster home ap-

proved list. So we have a lot of work to do in this area, and this is one of those issues that really tightly is wound into bringing better care to our children across this country.

And I now yield time to Mr. Doggett for his opening statement.

Mr. DOGGETT. Thank you, Mr. Chairman.

I certainly share all the sentiments that you just expressed and appreciate this bipartisan inquiry. I think that while no doubt medication can be one appropriate tool in a treatment plan for some children, it has instead become the first line of consideration for too many children in our foster care system.

The Congressional Research Service looked at the year 2010 and found that 40 percent of children in longer-term foster care over the age of 6 were using psychotropic medicines. That is a pretty staggering level. Other studies found the next year, in 2011, that those who are enrolled in Medicaid, children in foster care were prescribed psychotropic medications at rates of 3 to 11 times higher than nonfoster children. The pill is not the answer in many of these situations.

Having been abused or neglected and then removed from their homes, every child coming into the foster care system has suffered some degree of trauma. We have heard firsthand in this committee about the problems with psychotropic drugs a couple years ago and continue through our research to see other examples of that, and we have heard firsthand from foster children about the trauma and how it has impacted their lives. This issue was addressed in this committee when our colleague, Chairman McDermott, chaired the committee back in 2008 and required States to develop health oversight plans for children in foster care, including the oversight of prescription medicines. In 2011, Congress strengthened that provision to include specific protocols for reviewing the prescribing of these medications to foster children.

I look forward to hearing from each of our witnesses on how child welfare and Medicaid policies have changed in response to these specific laws. My home State of Texas, with the leadership of CASA, the Court-Appointed Special Advocates, recently changed the law there and took a number of steps to prevent unnecessary overmedication of children in foster care including the legislation that will give guardian ad litems a greater role in the oversight of these medications. Improved oversight of medications is only part of the solution. Children in foster care need access to comprehensive treatment for mental and emotional health needs, which requires additional efforts in both Medicaid and the child welfare system.

I appreciate the presence here today and the leadership for this hearing from our colleague Karen Bass of California who heads our Foster Care Caucus. The administration's budget calls for $750 million over the next 5 years toward this goal. This is an investment that is equal to about one-quarter of 1 percent of one of the measures that our committee approved earlier today. I believe that we do need to come together with common purpose and hear of any ways we can change the law in this area, but we also have to have the resources present to be able to get the job done effectively and not just respond after some crisis or horrible situation has hit the news media.

Thank you, Mr. Chair, and I look forward to hearing from our witnesses.

Chairman REICHERT. Thank you, Mr. Doggett.

I would like to just mention briefly, I would like to thank Ms. Bass for her work in helping us organize this hearing and her work in helping foster children. It is a pleasure to have you attending our hearing this morning, and also a moment just to thank Mr. McDermott for his hard work as past chairman and past ranking member of this committee and also Mr. Doggett for his support. So, as you can all see, this is a bipartisan effort, rarely seen. We are together on this, and we are going to make a difference and help people.

So thank you again, Mr. Doggett.

Without objection, each member will have the opportunity to submit a written record and statement and have it included in the record at this point. I want to remind our witnesses to please try and limit your testimony to 5 minutes. However, without objection, all of the written testimony will be made a part of the permanent record, and on our panel this afternoon, we will be hearing from JooYeun Chang, Associate Commissioner of the Children's Bureau Administration for Children and Families, U.S. Department of Health and Human Services; Dawna Zender Hovenier, the Mockingbird Society; Dr. Phil McGraw, talk show host, "Dr. Phil Show"; Dr. Michael Naylor, M.D., Associate Professor of Psychiatry, School of Medicine, University of Illinois at Chicago; and Stephen Lord, Director of Forensic Audits and Investigative Services, U.S. Government Accountability Office.

I would like to mention that we have other experts in the audience who know a thing or two about the foster care system because they have lived it, and as I mentioned just a little bit earlier, a lot of our foster youth are in the audience today, and I think we probably have over 60. And you know what, I am going to do something a little bit unusual, I am going to ask the foster kids, if they want to, to raise your hand or stand because we want to give you a big applause, round of applause for your success.

As you can see, they are not shy. We are so happy to have you here. So each of these youth have spent the morning with a Member of Congress, and as I said, Courtney and I got to spend a little time together and talk about my life and her life. We found some similarities as runaways, but I was fortunate enough to make it back to my home and not into a foster home. So thank you for coming today.

Ms. Chang, please proceed with your testimony.

STATEMENT OF JOOYEUN CHANG, ASSOCIATE COMMISSIONER OF THE CHILDREN'S BUREAU, ADMINISTRATION FOR CHILDREN AND FAMILIES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ms. CHANG. Thank you.

Chairman Reichert, Ranking Member Doggett, and Members of the Subcommittee, thank you for inviting me to testify today.

The administration is very concerned about the overmedication of children in the foster care system. We are grateful to you for having this hearing and bringing more attention to the issue. My name

is JooYeun Chang, and I am the Associate Commissioner of the Children's Bureau. I have worked as a national advocate on child welfare policies, both as a senior staff attorney at the Children's Defense Fund as well as at Casey Family Programs Foundation, where I worked closely with State and local child welfare agencies.

In my current role, I oversee the Federal foster care and adoption assistance programs as well as a range of prevention and post-permanency initiatives. At the Department of Health and Human Services, we are working with State child welfare agencies to ensure that vulnerable children in their care receive appropriate care and services and that they are effectively monitoring for psychotropic medication use.

Children who come into foster care often have been exposed to multiple traumas, including abuse and neglect and subsequent removal from their homes. The CDC's Adverse Childhood Experiences Study and other research tells us that the impacts of these negative life experiences affect children in all domains, from brain development to physical health, to how a young person reacts emotionally to various situations and how they are or are not able to interact with others.

We know from our research that children who enter foster care are at much higher risk for developing both physical and emotional disorders, especially traumatic stress, and the child welfare system currently struggles to fully meet their needs. If inadequately treated, these experiences can lead to worsening health conditions and may hinder a foster parent's ability to meet the child's needs, potentially resulting in multiple placements for that child.

This lack of stability can lead to increasingly restrictive and costly placements and make it more difficult for that child to find a permanent, loving family. These undesired outcomes can negatively impact the well-being of children and youth in foster care and also mean additional cost for the child welfare and other public systems. The need for action in this area is clear.

Our own data show that 18 percent of children in foster care are taking one or more psychotropic medications, and the GAO has estimated an even higher rate of 21 to 39 percent. Children in care are prescribed psychotropic medications at far higher rates than other children served by Medicaid and often in amounts that exceed those indicated by FDA approved labeling for such drugs.

We appreciate the important role that Congress, led by this committee, has played in bringing attention to these issues, specifically the 2008 enactment of Fostering Connections to Success and Increasing Adoptions Act, which required for the first time ongoing oversight and coordination of health care services for children in foster care, to the more recent enactment of the Child and Family Services Improvement and Innovation Act in 2011 that requires States to report to HHS protocols they have in place for monitoring the use of psychotropic medications.

We have worked across the agency and collaboratively across the Department to provide guidance to States on monitoring the use of psychotropic medications for children in foster care, and we have also shared information about evidence-based interventions that address the underlying issues of trauma. We reviewed the progress

that had been made and saw that there was a practice gap that needed to be filled.

Child welfare agencies often did not have access to adequate research-based nonpharmaceutical mental health treatments and, as a result, often rely on medication as a first line of treatment. If we are serious about reducing the use of psychotropic medication, we must also ensure that child welfare agencies have access to evidence-based interventions. Therefore, along with CMS, we developed the proposal you see in the President's fiscal year 2015 budget, one we hope you will give thoughtful consideration to. This proposal presents a concerted effort to reduce overprescription of psychotropic medications for children by increasing the availability of evidence-based psychosocial treatments that meet the complex needs that children who have experienced maltreatment often have.

Increased access to timely and effective screening, assessment, and nonpharmaceutical treatment will reduce overreliance on psychotropic medication, improve child emotional and behavioral health, and increase the likelihood that children in foster care will exit to positive, permanent settings with the life skills and resources they need to be successful.

The administration looks forward to working with you to address this crucial issue and improve services to some of our most vulnerable young people. Again, thank you for the opportunity to speak with you today. I would be happy to answer any of your questions.

Chairman REICHERT. Thank you, Ms. Chang.

[The prepared statement of Ms. Chang follows:]

Chairman Reichert, Ranking Member Doggett, and members of the Subcommittee, thank you for inviting me to testify. The Administration is very concerned about the over-medication of children in the foster care system. We are grateful to you for having this hearing and bringing more attention to the issue.

I am Joo Yeun Chang, Associate Commissioner of the Children's Bureau. I have worked as a national advocate on child welfare policies both as a senior staff attorney at the Children's Defense Fund and immediately prior to my appointment to the Bureau, I worked at Casey Family Programs Foundation where I worked closely with state and local child welfare agencies. In my current role, I oversee the Federal foster care and adoption assistance programs as well as a range of prevention and post-permanency initiatives.

At the Department of Health and Human Services (HHS), we are working with the state agencies that run child welfare systems to ensure that the vulnerable children in their care receive the proper medication. As victims of abuse or neglect, these children often need help dealing with their difficult experiences and, in recent years, the abiding impacts of traumatic experiences has become clearer through research.

Children who come into foster care often have been exposed to multiple acute and chronic traumas, including abuse or neglect and subsequent removal from their homes. The Centers for Disease Control and Prevention's Adverse Childhood Experiences Study and other research studies tell us that the impacts of these adverse experiences affect children in all domains: cognitive functioning, physical health and development, emotional and behavioral functioning, and social functioning. We know from the research that children who enter foster care are at a much higher risk for developing both physical and emotional disorders and the child welfare system currently struggles to fully meet their needs. If inadequately treated, these experiences can lead to worsening health conditions and may hinder a foster parent's ability to meet the child's needs, potentially resulting in multiple placements. This lack of stability can lead to increasingly restrictive and costly placements and make it more difficult for that child to find a permanent family. These undesired outcomes can negatively impact the well-being of children and youth in foster care and also mean additional costs for the child welfare and other public systems.

The need for action in this area is evident. HHS data show that 18 percent of the children in foster care were taking one or more psychotropic medications at the time they were surveyed (NSCAW II data collected October 2009 through January 2011). The Government Accountability Office has estimated an even higher range of 21 to 39 percent. Children in foster care are prescribed psychotropic medications at far higher rates than other children served by Medicaid, and often in amounts that exceed those indicated in Food and Drug Administration-approved labeling for such drugs. Many psychotropic medications are not approved for use in children. And in the cases where they are approved for use in children, some of these medications are used off-label for other psychiatric conditions which are not approved for children.

We appreciate the important role that the Congress, led by this Committee, has played to bring attention to these issues. Specifically, the 2008 enactment of Fostering Connections to Success

and Increasing Adoptions Act, which required for the first time that child welfare agencies develop ongoing oversight and coordination of health care services for children in foster care to the more recent enactment of the Child and Family Services Improvement and Innovation Act in 2011 that requires states to report to the HHS protocols they have in place for monitoring the use of psychotropic medications.

We have worked across the agency, and collaboratively across the Department, to provide guidance to states on monitoring the use of psychotropic medications for children in foster care and have shared information about evidence-based interventions that address the underlying issues of trauma. For example:

In 2011, then Administration for Children, Youth and Families Commissioner Bryan Samuels testified before the Senate Committee on Homeland Security and Governmental Affairs about the importance of the issue and provided an update on HHS actions to that point.

In 2011, ACF, the Centers for Medicare & Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA) issued a Tri-Agency State Director letter to draw attention to the problem of inappropriate psychotropic medication use in foster care and to provide guidance about best practice approaches to medication oversight and monitoring.

In April 2012, ACF issued an Information Memorandum (IM) that helps states implement the new requirements of the Child and Family Services Improvement and Innovation Act and provides information on promoting the safe, appropriate, and effective use of psychotropic medication for children in foster care.

In spring 2012, ACF collaborated with CMS and SAMHSA on a three-part webinar series to help states with the development of the psychotropic medication oversight and monitoring components of their title IV-B plan.

In August 2012, ACF, CMS, and SAMHSA co-hosted a summit for state child welfare, Medicaid, and mental health officials on strengthening the management of psychotropic drugs for children in foster care.

In August 2012, CMS released an Information Bulletin containing additional information regarding managing the use of these drugs in vulnerable populations.

In July 2013, ACF, CMS, and SAMHSA issued another Tri-Agency State Director letter encouraging the integrated use of trauma-focused screening, functional assessments, and evidence-based practices to improve child well-being.

Since 2011, ACF has awarded a total of $24 million in 18 states and the District of Columbia to promote the use of evidence-based interventions to improve social and emotional well-being of children in foster care.

After conducting these activities, we reviewed the progress that had been made and saw that there was a practice gap that needed to be filled. Child welfare agencies did not have access to

the research-based, non-pharmacological, mental health treatments for the conditions for which many of these children were being medicated.

Therefore, along with CMS, we developed the proposal you see in the FY 2015 President's Budget, one we hope you will give thoughtful consideration.

The existing strong evidence-base in the area of trauma-informed psychosocial interventions warrants a large initial investment to expand access to effective interventions. The ACF proposal for $250 million over five years would fund infrastructure and capacity building, while the CMS investment of $500 million over five years would provide incentive payments to states that demonstrate measured improvement.

ACF's funded activities would include:

- Closely linking findings from screenings and assessments with the selection of appropriate interventions, and ongoing assessments would be used to monitor children's progress with treatment;
- Coordination between child welfare case planning and management and Medicaid, especially Early and Periodic Screening, Diagnosis, and Treatment (EPSDT);
- Training of child welfare staff, foster parents, adoptive parents, guardians, judges and clinicians to make informed choices about evidence-based trauma interventions for the children they work with and, for caregivers, to implement their roles in interventions that require strong home-based support. Beyond initial training, some interventions require booster trainings to ensure that fidelity to the models does not erode over time. The child welfare workforce also should develop literacy in the area of evidence-based practice to support the transition to evidence-based service delivery;
- Fidelity monitoring and ongoing coaching/supervision, which are critical to the delivery of evidence-based interventions. Without them, the integrity of the intervention is compromised, and expected results may not be achieved;
- Evaluation; and,
- Systems to support and improve coordination between state child welfare agencies, Medicaid, and behavioral health services.

CMS incentive payments would recognize state improvement through a combination of process and outcome measures that would be available to qualifying demonstration states. States would receive incentive payments for making improvements against a baseline of standardized, national outcome measures that could include an assessment of the appropriateness or overuse of psychotropic medications in foster youth, as well as measures employed to evaluate the impact of such use on youth in foster care.

This proposal presents a concerted effort to reduce over-prescription of psychotropic medications for these children by increasing the availability of evidence-based, psychosocial treatments that meet the complex needs of children who have experienced maltreatment. Increased access to timely and effective screening, assessment, and non-pharmaceutical treatment will reduce over-prescription of psychotropic medication as a first-line treatment strategy, improve their

emotional and behavioral health, and increase the likelihood that children in foster care will exit to positive, permanent settings, with the skills and resources they need to be successful in life.

The Administration looks forward to working with you to address this crucial issue and improve services to some of our most vulnerable young people.

Again, thank you for the opportunity to speak with you today. I would be happy to answer any questions.

Chairman REICHERT. And before Ms. Hovenier begins, I would just like to point out that she is quite a remarkable young woman, and as a 21-year-old alumni of Washington's foster care system, she spent 7 years in foster care, primarily in Pierce County in western Washington, just south of Seattle area. She has become a strong advocate for foster care reforms, working with the Mockingbird Society, an advocacy organization for young people impacted by foster care and homelessness in Washington State. And I know she hopes her advocacy will improve the foster care system for young people who come after her, and I believe that you will.

Thank you for being with us today, and you can go ahead. She says she is not nervous. I told her I was.

But go ahead, you have 5 minutes, Ms. Hovenier.

STATEMENT OF DAWNA ZENDER HOVENIER, THE MOCKINGBIRD SOCIETY

Ms. HOVENIER. Thank you, Chairman Reichert, Ranking Member Doggett, and committee members for giving me the opportunity to speak.

My name is Dawna Zender Hovenier. I am 21-years old and have spent 7 years in foster care in Washington State. On my 18th birthday, I aged out of foster care and was released after spending 7 months in an adolescent psychiatric hospital.

My hope is that the government will quit spending millions of dollars forcing kids like me to take drugs they do not need and give them things they do need, such as a volunteer CASA who believes in them, skilled mental health professionals who they can talk to and, most of all a loving, compassionate family that believes in them.

I was ordered into the psychiatric hospital after my social worker told the court I had borderline personality disorder, major depressive disorder, and suicidal ideation. I was forced to take strong doses of psychotropic medication and told I could probably never live on my own. Only my CASA and the man who became my father agreed with me that I did not need the drugs.

The 7 months I was locked up and forced to take these drugs felt like being in jail. After reviewing my records, I discovered that the foster care system paid $15,000 a month, about $120,000 total, to lock me up and take these drugs.

Last year, I earned my certified nurses aide certificate after successfully completing 2 years of classes at Bellingham Technical College. My GPA? It was a 3.92. I am currently enrolled at Whatcom Community College in Bellingham, Washington. Thanks to Federal and State funding for former foster youth, I was able to complete all my prerequisites required for a nursing degree. I am hoping to be accepted into an RN program to pursue my dreams of becoming a nurse.

I have lived independently for more than 2 years. I have been off all psychiatric medications for more than 3 years. I have never felt better or happier.

What happened? How did I transition from being diagnosed a mentally disabled foster youth to a model student and productive member of society? I don't have time to tell my whole story. Despite everything I experienced growing up, I know I was lucky.

When I was 16, the man who recently became my father and is here with me today adopted my then 10-year-old brother from foster care. My younger brother was also forced to take strong doses of psychiatric drugs. He has been off them since his adoption more than 5 years ago.

My dad hired an attorney to fight the State's plan to transfer me to an adult psychiatric facility. He picked me up on my 18th birthday and sent me to live with his friends. They are now my family, too. So today it feels like I have two dads and a mom.

The next 6 months were among the most difficult in my life. Because of my diagnosis in foster care, we could not find a psychiatrist willing to take me off the medications, so we had to do it ourselves. This meant battling many intense withdrawal symptoms. One of the medications I was on can cause seizures, resulting in death if not carefully discontinued. My dad wrote a book about adopting my brother from foster care, and some of the professionals who read it advised him on how to get me off these medications.

Six months after aging out of foster care I managed to graduate from Mount Baker High School with my class. A few months later, I moved into my own apartment. My new family helped me find an excellent therapist, who supported me in my decision to get off these medications.

Today I am able to talk about my feelings, but when I was in the psychiatric hospital, I was so drugged up, I didn't even know how I felt. My twin sister said I was like a zombie. I know some of the kids I was locked up with needed medication. They heard voices that weren't there and got violent sometimes, but I believe many of the foster kids were like me and needed loving parents to guide them.

When I think about the government spending over $120,000 locking me up and forcing me to take these drugs, it makes me very angry. I wish that the money could have been spent helping foster youth.

Despite all of this, I have been so lucky. A few months ago, on the same day as my brother's adoption 5 years ago, my dad adopted my twin sister and me. What really helped me get off the medication was being surrounded by people who loved me and wanted to help me. I believe what most foster youth need is love, not drugs.

Although I can never get back the 7 months that I was locked up and forced to take these drugs, I hope that telling my story here today and continuing to work with the Mockingbird Society will help other youth like me and encourage change.

In closing, I want to thank the Mockingbird Society for making it possible for me to come from Seattle to be here today. They are an awesome youth advocacy organization that helps young people share our experiences about foster care and gives us a chance to be heard.

Thank you, Chairman Reichert, for inviting me here today. I want to thank you for all the work you do for foster youth.

Dr. Phil, I also want to thank you for everything you have done.

And I am grateful to my CASA for being the person who knew me and told the court that I did not need these drugs, and for all

my family, my twin sister, and my therapist for supporting me to get off these medications. Thank you.

Chairman REICHERT. You did awesome. You want to come up here and take my place and run the rest of the show?

Ms. HOVENIER. No thank you.

Chairman REICHERT. No? Thank you for your testimony and thank you for your work.

[The prepared statement of Ms. Hovenier follows:]

Dawna Zender Hovenier
Written Testimony
House Ways and Means Subcommittee on Human Resources
Are We Overmedicating Children in Foster Care?
May 29, 2014

Thank you Chairman Reichert, Ranking Member Doggett, and Committee members for giving me the opportunity to speak. My name is Dawna Zender Hovenier, I am 21 years old and I spent seven years in foster care in Washington State. On my 18th birthday, in December of 2010, I aged out of foster care and was released after spending seven months in a lock up adolescent psychiatric hospital.

My hope is that the government will quit spending millions of dollars forcing foster kids like me to take drugs they do not need and help give them things they do need such as a volunteer CASA who believes in them, skilled mental health professionals who can talk to them and most of all a loving home with compassionate parents that believe in them.

I was ordered into the psychiatric hospital after my social worker told the court I had Borderline Personality Disorder, Major Depressive Disorder and suicidal ideation. I was forced to take strong doses of psychiatric medications and told I could probably never live on my own. Only my CASA and the man who became my father agreed with me that I didn't need the drugs. The seven months I was locked up and forced to take drugs against my will felt like being in jail.

After reviewing my records, I discovered that the foster care system paid almost $15,000 a month, about $120,000 total, to lock me up and take psychiatric drugs that I did not need.

Last year I earned my Certified Nurses Aide certificate after successfully completing two years of classes at Bellingham Technical College. My GPA was a 3.92. I am currently enrolled at Whatcom Community College in Bellingham, Washington. Thanks to federal and state funding for former foster youth, I was able to complete all my prerequisites for a nursing degree, and I am hoping to get accepted into an R.N. program to pursue my dream of becoming a nurse.

I have lived independently for more than two years. I have been off all psychiatric medication for more than three years. I have never felt better or happier.

What happened? How did I transition from being diagnosed a mentally disabled foster youth to a model student and productive member of society?

I don't have time to tell my entire story. Despite everything I experienced growing up, I know I was lucky. When I was 16, a man who recently became my father and is here with me today, adopted my then 10-year-old brother out of foster care. My younger brother was forced to take psychiatric drugs in foster care too, but he has been off them since his adoption more than five years ago. My dad hired an attorney to fight the state's plan to transfer me to an adult psychiatric facility. He picked me up on my 18th birthday and took me to live with his friends. They are my family now too, so today it feels like I have two dads and a mom.

The next six months were among the most difficult in my life. Because of my diagnosis in foster care, we couldn't find a psychiatrist willing to take me off the drugs, so we had to do it ourselves. This meant battling the intense withdrawal symptoms: one of the medications I was on can cause seizures resulting in death if discontinued hastily. My dad wrote a book about adopting my brother from foster care, and some of the professionals who read it advised him how to get me off all the medications.

Six months after aging out of foster care, I managed to graduate from Mount Baker High School with my class. A few months later, I moved into my own apartment. My new family helped me find an excellent therapist who supported my decision not to take drugs. Today I am able to talk about my feelings, but in the psychiatric hospital I was so drugged up I never knew how I felt. My twin sister said the drugs made me seem like a zombie.

I know some of the kids I was locked up with needed medication. They heard voices that weren't there and sometimes got violent, but I believe many of the kids were like me, and didn't need to be drugged. What they needed was a family that loved them and parents to guide them. When I think about the government spending more than $120,000 locking me up and forcing me to take drugs I did not need, it makes me angry. I wish the money could have been spent helping foster kids instead of harming me.

Despite all of this, I've been so lucky. A few months ago, on the same day as my brother's adoption five years ago, my dad adopted my twin sister and me. What really helped me get off the medication was being surrounded by people who loved me and wanted to help me. I believe what most foster kids need is love, not drugs.

Although I can never get back the seven months that I was locked up and forced to take drugs against my will, I hope that telling my story here today and continue to work with the Mockingbird Society will help other youth like me and encourage change.

In closing, I want to thank the Mockingbird Society for making it possible for me to come from Seattle to be here. They are an awesome advocacy organization that helps young people like me share our experiences to improve the foster care system and gives us a chance to be heard.

I'll always be grateful to my CASA for being the one person who really knew me and who told the court that he agreed with me that I didn't need medication and I'll be forever grateful to my dad for adopting me, and for all my new family, my therapist, and twin sister for giving me the support I needed to stop taking psychiatric medication I did not need and become who I am today.

Thank you Chairman Reichert for all the work you do for foster kids and for inviting me here to speak.

Chairman REICHERT. Dr. McGraw, you are recognized for 5 minutes.

STATEMENT OF PHIL MCGRAW, PH.D., TALK SHOW HOST, "DR. PHIL"

Mr. MCGRAW. Chairman Reichert, Ranking Member Doggett, and distinguished Members of the Committee, I wish I didn't have to follow this young lady. That is a tough act, to say the least.

I am honored to be invited here to talk about the possible misuse of these psychotropic drugs. They are all too often prescribed to America's foster children. Look, these drugs can change and even save lives, there is no question about it, but when it comes to these vulnerable children, these drugs are just too often misused as chemical straitjackets. It is just a haphazard attempt to simply control and suppress undesirable behavior rather than treat it, nurture it, and develop these treasured young people, and simply put, it just makes them less inconvenient. It just makes them less inconvenient so they don't take as much energy to manage.

And you have my written statement, and I kind of want to begin where it leaves off because I believe that 80 percent of all questions are really statements in disguise. And I think everybody here already agrees, these drugs are flowing too much; there is just no question about that. You know the numbers.

The real question is why? You know, why is this happening? I mean, three times as many foster children as their counterparts are getting these drugs; 40 percent of them are on three classes of drugs, some are on five classes of drugs. This is polypharmacy. Is there more psychopathology with these foster children? Of course, there is. They have more abuse and neglect that they have had to go through. Eighty percent are diagnosed with mental illness as opposed to 20 percent in the general population, but this is no justification.

I have been working with this population for 5 years, for five decades. Robin and I have been national spokespersons for CASA for a number of years. Their budget has been cut, which just broke my heart to see. These kids face problems that you are not going to fix by throwing drugs at them. And a lot of them don't even take the drugs; they sell them. Dr. Charles Sophy is with me here today. He is the chief medical director for the L.A. County DCFS, the largest in the country. He told me within the last month, near a shelter in L.A., some of those children tried to sell him their psychotropic drugs, not knowing he was the medical director, and more than once in an hour trying to sell the drugs. If they do take them, are they less inconvenient? Maybe. But it is not convenience without consequences.

They should never be used without evidence-based research. There should be proper diagnostics done and appropriate monitoring done, and it should always be in conjunction with evidence-based therapies, and anything less, we just have to be honest, we are sabotaging these kids, we are just flat out sabotaging them. And in my view, this is like pulling a thread. The entire system is flawed. It is not just the drugs. The entire system is flawed. Do we need to turn off the flood of drugs? Yes. But the problem is we have got a reverse incentive system here. It is a system where the

government continues to pay for the drugs. We say you shouldn't give them, but yet they continue to be compensated for them, and these foster children, the more labels they get, the more drugs they are on, the more money they get to take care of that child. So they are actually paid for pathology. The more scripts, the less treatment, the more scripts, the less energy, and so it just becomes an assembly line, high volume, move them in, move them out process, and these children deserve better than that.

Real treatment takes high energy, it takes—it is low volume. I mean, you have got to have more people, it takes more time, but we have got too many doctors with insufficient training in these drugs. They don't know what the drugs do. We don't—most of us, if we are honest, we have to tell you, we don't know why the drugs work when they do work. We don't know the agent of action, the agent of change, but we have too many doctors with insufficient training about these drugs that are prescribing them, and there is no follow up because the foster parents change. So there is no long-term follow on this, and then the therapists they do get, they change. You have got children with detachment problems, attachment disorders, detachment problems, and we rotate their therapist in and out. As soon as they bond with one, then they are faced with another one. So it just becomes a serious problem.

I have been in this situation, hopefully, fortunately not as bad as some of these children, but I was homeless when I was 15 years old. I was living on the streets in Kansas City. I was living in a car. We finally got a room at the YMCA, my dad and I, and then ultimately an apartment where we got an apartment, but we had no utilities because we didn't have money for the deposit. So we froze to death in the dark from 4:30 on, but I tell you what happened to me. Nobody ran at me with a handful of drugs. I fortunately had a football coach and some others who taught me about responsibility, taught me about the things to do that were important, and that is what CASAs do with these children. That is what therapists involved with evidence-based treatments would do with these children. But we have got to stop the flow of drugs and we have got to focus on reunification. We have just got to try to get these children back home.

This system is broken, and it is flawed, and psychology has made great strides. We truly do have alternatives to offer these children, and without the side effects that the drugs have, but it takes time and it takes money, and it takes a completely different model than what we have right now, and so I am obviously very passionate about this.

I just feel so strongly that these children need somebody to put an arm around their shoulder, somebody to help them, rather than just throw drugs at them, and there is nothing better for these children than to be able to look themselves in the mirror and say, I did this, I found my way, I got my coping skills.

So I will stop. I want to thank the committee for inviting me to participate. A wise man once said—well, actually it was me that said it, you can't change what you don't acknowledge. And this committee is making a bold acknowledgment of this problem, and so I am happy to answer any questions.

I have Dr. Frank Lawlis, the chairman of my advisory board here; Dr. Charles Sophy, who I mentioned earlier, is here; Dr. Marty Greenberg, our director of professional affairs, is here. We are all here to answer any questions anybody has got. We want to change this model. We want to start taking care of these kids. They have been through enough.

Chairman REICHERT. Thank you. Well, we didn't even have to hold up an applause card on that one. I wish we had a half hour show, Doctor, but that was great testimony. Thank you so much. You and I have a couple of things in common. One, I ran away and lived in my car. It was a 1956 Mercury for me; I don't know what you had.

Mr. MCGRAW. 1955 Chevy, no reverse. It had no reverse, but it did go forward.

Chairman REICHERT. And it was a football coach that came to help me, too, so thank you for your testimony.

[The prepared statement of Mr. McGraw follows:]

INCONVENIENT YOUTH:
THE OVERMEDICATION OF CHILDREN IN FOSTER CARE

COMMITTEE ON WAYS AND MEANS SUBCOMMITTEE ON HUMAN RESOURCES

TESTIMONY BY DR. PHILLIP C. MCGRAW, PH.D.

THURSDAY, MAY 29, 2014

Chairman Reichert, Ranking Member Doggett and esteemed members of the Committee. I am honored to be invited to appear before you to participate in this critical discussion concerning the possible misuse of prescription psychotropic medications. These drugs are all too often prescribed to America's foster children. I believe evidence shows these medications are too frequently, and sometimes even recklessly, prescribed to children in the foster care system and others with limited access to quality medical and psychological care.

Prescription psychotropic drugs can change and even save lives, but when it comes to these vulnerable children, these drugs are too often misused as "chemical straight jackets." This is a haphazard attempt to simply control and suppress undesirable behavior, rather than treat, nurture and develop these treasured young people.

It is well documented that compared with the child and adolescent population at large, children in our nation's foster care system exhibit higher rates of emotional distress and mental illness. Sadly, they endure a far greater frequency and variety of horrific events, abuse, neglect, and trauma than children who live with intact families. Consequently, they experience increased educational and developmental deficits, and a higher frequency of diagnosed mental illness.

Approximately 20 percent of children in the general population are diagnosed with a mental disorder. In the foster care population, estimates are as high as 80 percent. We would certainly expect to see more of these children for whom psychotropic medication is appropriate, if not essential, but even then, there are grave concerns the evidence does not support the excessive prescribing pattern we see.

The reality is medication cannot put the psycho-social horse back in the barn. These kids deserve to live in safe environments where healthy behaviors are observed and modeled. A rush to medication creates a more manageable world for caregivers, teachers, and courts, but have we really helped these under-served children? Throwing drugs at the problem may make them "less inconvenient" in the moment, but is *convenience* a justification for higher rates of psychotropic drug therapy? I pray to God the answer is no, no, no. Looking for a drug just because it is calming and constrictive is wrong on so many levels. Long-term solutions cannot and will not be found in a pill

bottle. So how *do* we determine the *appropriate and necessary* use of prescription psychotropic drugs with these children?

To answer this question, we must *ask* several more. When psychotropic drugs are used, is the use supported by evidence-based research? Has there been an appropriate diagnostic formulation reached by a *qualified* health care professional using well-established criteria? Once prescribed, is there appropriate monitoring of these medications for efficacy and side effects? Are medications used in conjunction with psychological and behavioral interventions?

If the answer to any or all of these questions is no, and I fear too often this is the case, then the bottom line is we stand by as these children are actually sabotaged in two very significant ways. First, they may be getting inappropriate and over-prescribed psychotropic drugs. Secondly, they are *not* receiving the evidenced-based treatments they actually need. This is a double or even triple "bad deal." Think about it. If you make a wrong turn and go five miles in the wrong direction, that is a 15-mile mistake! You go 5 miles in the wrong direction, you have to come back 5 miles and then begin to go the 5 miles you should have started with! These children go through enough without being run all over hell and half acre. They desperately need to get the appropriate help they need, at the precise time they need the help. Let us begin to embrace the gold standard and do only what is "In the best interest of the child."

We can and must because these children deserve better. I think old sayings get to be old because they make good sense. To quote an old saying here, we need to become part of the solution for these children and not part of their problem. We must put an end to our lazy, poorly conceived and antiquated care plans.

Like so many things in life there is a *right way* and a *wrong way* to do things. Based on my academic training, my experience as a clinical psychologist and my work alongside both adult and pediatric psychiatrists, I have seen firsthand the benefit of these medications when prescribed under the proper circumstances. I have also seen the damage done when the drugs are used by health care professionals with inadequate training and experience in the treatment of behavioral and mental disorders. Their lack of understanding of the medicines they so readily prescribe, coupled with insufficient training in the measurement and diagnostic criteria that is so essential, hinders the development of a quality, comprehensive treatment plan. These children deserve better than to be part of an assembly line style of medicine. Move 'em in, move 'em out! There just has to be a better solution.

I know this population because I have worked closely with them for years. So many of these children are just your normal everyday kids who live in extremely atypical circumstances. We must properly differentiate between psychological, medical and neurological etiology for the behavioral and emotional problems before choosing a treatment plan. We cannot allow *some* foster parents and ill-informed, albeit well-

intended, health care providers to simply default to psychotropic drugs because it is an easier, "seemingly" more convenient solution. Solutions that may seem efficacious in the short term might be devastatingly disruptive in the long run. The goal simply cannot be to make raising these children less demanding in the moment.

These are not theoretical concerns or hypothetical scenarios. These are real situations unfolding as we speak. At increasingly alarming rates, we find these drugs being *over prescribed* and *inadequately monitored*. Data show that over 40 percent of children in foster care are taking three or more prescription medicines from different classes of drugs, including antidepressants, anxiolytics, antipsychotics, stimulants, mood stabilizers and hypnotics. Some are taking medications from *five* different classes of drugs, including children under the age of one year. *There is not one shred of research or scientific evidence that this is effective, or even safe!*

The lack of research and published data is all the more puzzling to me because the FDA has established an incentive for testing medicines designed for adults to be used with children with various bolt-on pediatric marketing exclusivities. Hopefully, pharmaceutical companies will take advantage of this incentive and help us understand how, when, and when not, to use their products in children. A more active partnership and dialogue can only serve to benefit these children.

But, it is in the trenches where the prescription pen becomes the mighty sword in this battle. This is where the abuse is happening. This is where the drugs are mis-used as weapons to subdue and *control* behavior. Again, let me reiterate, I am *not* talking about the *appropriate* use of these medications when prescribed by specialty-trained professionals in conjunction with evidence-based behavioral therapies. In those cases, many of these drugs provide profoundly positive effects.

The risks of this polypharmacy, the use of multiple drugs from multiple categories, is unfathomable. Research does not support this practice and drug-to-drug interactions potentially create more problems than they solve.

As if this were not enough, it seems that government-run programs are subsidizing these negligent practices. Medicaid and similar state-run programs pay for the cost of medical care for most of these children in foster care. It is reported these children are prescribed psychotropic medications at more than *three times the rate* of lower-income children from intact families who also are covered by Medicaid. This needs to and must be further investigated.

The time is now for good science and *not convenience* to be our guide. If research does not support *the way* we practice, we must *reexamine* the way we practice. We are long past due in looking at the research to determine if these drugs are effective, or for that matter, even safe.

Further, it is time to look at the foster children on an individual, case-by-case basis. They are not a "one size fits all" population. As I said, and cannot emphasize to you enough, some of these children have **no mental illness** or disorder whatsoever, yet they are medicated.

Others actually *do* have a legitimate illness or disorder but are **improperly diagnosed** by caregivers either not properly skilled or unaware of how to access or rule out relevant diagnostic criteria. For example, someone in a manic phase of bipolar disorder might erroneously be diagnosed with ADHD and therefore be given medication lacking therapeutic efficacy and in fact it could potentially have the effect of pouring gas on a fire.

Still other foster children may be **properly diagnosed but improperly treated** with medications with no scientific support for use with that particular disorder. This is especially disturbing when we have non-medication treatment techniques that *are* proven effective, **and very importantly, do not have the long list of medication side effects.**

We must not forget the standard of care in the prescribing of psychotropic medication requires **appropriate monitoring**. This is oftentimes difficult and time consuming, but it comes with the territory. Without proper monitoring, drugs have the potential to delay the development of normal adaptation processes, which can further handicap a child. The over reliance on medication, without proper behavioral interventions, does nothing to help a child develop coping and problem-solving skills essential for educational, social and moral development. These are the very skills needed to overcome their history and help fill the gaps in their development that led them into the foster care system.

Even the appropriate use of medication in some disorders can place a child at greater risk for future dependence on prescription or non-prescription drugs. We know that many of these drugs have addictive elements.

The absence of this monitoring results in more than just a few foster teens actually selling their drugs on the street rather than taking them.

Dr. Charles Sophy, a highly skilled and experienced psychiatrist and Medical Director of the Los Angeles County Department of Children and Family Services, recently shared with me a shocking anecdote. It seems some of the children in the foster care system in LA approached him on a street near a shelter. Without realizing who he was, they attempted to SELL him the psychotropic drugs they had been prescribed. Instead of taking them, they chose instead to turn the pills into a source of cash! Streets leading up to certain shelters are referred to by some of these children as "the gauntlet." Those seeking shelter there believe they first have to run a "gauntlet" of drug dealers and other predators hanging around there knowing these children are coming by. These are

the very same children and the very same drugs we are talking about here today. It happened more than once in less than an hour!

This story is to me both staggering and frightening. One can only hope foster parents and prescribers notice if drugs important enough to prescribe weren't even being taken! We are the grown ups here. Aren't we the ones responsible enough to pay closer attention to these at risk youth who so desperately need our support and guidance?

The news is not all dreary. Psychological science has advanced tremendously over the past 15-20 years. We have evidence-based behavioral treatments known to be very effective in producing positive behavior change. Applied consistently by professionals, parents and schools, the results are far more enduring than the use of stopgap measures like prescription drugs. These techniques are effective. They do not have dangerous side effects. They empower children by demonstrating behavior change is not only possible, it is a result of their own efforts. It engages children in the process and in the solution.

Imagine the feeling these children can experience knowing they possess the skills needed to succeed in this world. To look at yourself in the mirror and have the tools, the confidence, and know, "I can do it!" I personally can think of no greater gift. The loving arms these hero foster parents provide these children are also immeasurable in impact. (God bless the foster parents!)

Having said that, I would like to add a very personal note to this discussion. When I was a teenager, there was a brief but memorable period of time when I was homeless. I remember all too well the feeling of hunger, cold and most devastatingly, the feeling of being *alone*. I remember the struggle trying to go to school, to fit in with peers who had a family, a bed, and a meal awaiting them at the end of the day. I was living in a parallel universe.

I'll never forget the feeling of relief when my father and I were able to move from our car to a small room in a YMCA, and then finally to an apartment. It would be several months before we could afford the deposit required to turn on the electricity. This was my life at the time. No one suggested mind-altering drugs to help me feel better or act differently. What I did have were people in my life who believed in me and helped me believe in myself. One particular football coach allowed me to be a part of a team when I was an outsider and needed very much to *belong* somewhere. I learned what it means to be resilient and not to view myself as a victim. I faced the responsibility for my actions, my failures, my future. Sometimes, nothing is more powerful than a child feeling a caring adult's arm around his or her shoulder to guide them through the maze of life. Foster parents are by and large unsung heroes. My wife Robin and I have had the great honor of being national spokespersons for "CASA," the Court Appointed Special Advocates program, for the last several years.

It is the responsibility of each and every one of us to teach America's foster children the skills they need to be happy, productive citizens. This wisdom comes from a unified and integrated system that truly creates the conditions under which a disadvantaged youth can navigate a course filled with obstacles, and with the finish line in sight, find the strength, determination, motivation and courage to cross the line to success.

Fortunately, there *are* those involved in this important work that "get it" and get it in a big way. There are some extraordinary efforts under way to do the right thing and make a difference in the lives of foster children. The GAO produced a very important document which not only comprehensively assesses this problem, but provides meaningful guidance to states on best practices for overseeing psychotropic prescriptions for foster children. The Texas Department of Family and Protective Services and the University of Texas College of Pharmacy have provided a well reasoned set of general principles evaluating medication utilization parameters for children and youth in foster care. The Illinois Department of Children and Family Services has developed a very comprehensive set of guidelines for the practice of pediatric pharmacology developed specifically for this population. Many of these, and other entities, have brought us closer to what is hopefully becoming the standard of care in the use of psychotropic prescribing in children and adolescents.

I want to conclude my remarks by saying, like many of you, I am grateful for all the opportunities I have for health, love, hopes and dreams for my own children and grandchildren. I recognize all children are not this fortunate. The 400,000 children in this great country who are placed in foster care *each year* due to abuse and neglect have neither the voice to advocate for themselves, nor the strength, maturity or resources to protect themselves. If we continue to throw drugs at them, drugs that in many cases are not even approved or recommended for children, are we not saying, "you are forgotten, you are not worth the effort of actual treatment, you are *inconvenient?*"

We must *all* step up to bridge the gap to take these children from victims to victors. We must and can do better.

I want to thank this Committee for inviting me to participate in this very important forum so close to my heart. A wise man once said, (well actually it was me that said it), "You can't fix what you don't acknowledge." This committee is boldly acknowledging a problem. I feel confident the solutions are closer today because of your interest. I came today accompanied by Dr. G. Frank Lawlis, Psychologist and Chairman of the Dr. Phil Show Advisory Board, Dr. Charles Sophy, Psychiatrist and Medical Director of the LA County DCFS and also a member of our Advisory Board, who I mentioned earlier, and Dr. Marty Greenberg our Director for Professional Affairs. I, in fact, we, would be happy to answer any questions.

Chairman REICHERT. And Dr. Naylor, you are recognized for 5 minutes.

STATEMENT OF MICHAEL NAYLOR, M.D., ASSOCIATE PROFESSOR OF PSYCHIATRY, SCHOOL OF MEDICINE, UNIVERSITY OF ILLINOIS AT CHICAGO (UIC).

Dr. NAYLOR. Chairman Reichert, Ranking Member Doggett, and Members of the Subcommittee on Human Resources, before I start, I really want to lodge a complaint against who seated me here. He only had to follow one really incredible testimony. I have to follow two. I hope I can live up to it.

Thank you for inviting me to testify before the committee. I am truly honored at the opportunity to address the issue of psychotropic medications for kids in the foster care system. We have already heard children in foster care, by definition Medicaid-eligible, are at higher risk for developing severe emotional disturbances and utilize mental health services at higher rates than other Medicaid-eligible youth. They are prescribed more medications at higher rates and at higher doses. In a way, these are not particularly surprising findings. As a population, foster children have multiple risk factors that predispose them to severe emotional disturbances and psychiatric illnesses, including often of genetic predisposition to mental illness, in utero exposure to drugs and alcohol, the adverse effects of growing up in poverty, a history of severe trauma, disrupted early attachments, and multiple placement disruptions, to name just a few.

To complicate matters, there is the fragmented medical and psychiatric care system and an absence in the most part of a consistent caregiver to provide consent for and longitudinal oversight of their ongoing care. Despite all of this, I do contend that psychotropic medications are often an important component of a comprehensive psychosocial treatment plan that really is based on a good biopsychosocial understanding of these kids and their situation.

I will describe how a program designed and implemented by the Illinois Department of Children and Family Services to provide consent for and oversight of psychotropic medications in foster children has resulted in more effective, safer, and more cost-effective care.

In July 2007, I testified in front of the committee under Congressman McDermott and to advocate both for the oversight of psychotropic medications for foster children and to describe a program, the DCFS centralized psychotropic medication consent program. Illinois State law prohibits the administration of psychotropic medications to foster children without the consent of the DCFS guardian. And this is a centralized office compared to other consent programs across the Nation. To support the consent process, DCFS contracted with UIC to provide an independent review of all psychotropic medication consent requests to determine the appropriateness of the proposed treatment. Utilizing an extensive database consisting of consent data, Medicaid pharmacy payment claims, and data from the State-wide automated child welfare information system, we can monitor an individual's medication history over time, across placements, and across providers, and we can

monitor State-wide patterns of psychotropic medication use. We believe that this prospective psychotropic medication consent and oversight process has resulted in higher quality and more cost-effective care, as evidenced by the implementation of a program that provides specialty evaluations of and evidence-based psychosocial treatments for preschool aged children in an effort to decrease reliance on psychotropic medications, improved continuity of care preventing, therefore, on the use of medications that have perhaps proven ineffective or been associated with significant adverse effects in previous trials, increased adherence to evidence-based prescribing for the treatment of psychiatric disorders, in the meantime resulting in a cost savings, a substantial decrease in the concurrent prescription of two or more antipsychotic medications, improved monitoring of adverse side effects, for example, documenting the weight gain associated with second-generation antipsychotics, and devising a policy linking consent for these medications to appropriate medication oversight in the doctor's office, and finally, improved safety of pharmacotherapy through the prevention of potentially serious and even fatal drug-drug interactions.

In conclusion, I will reiterate my 2007 testimony in support for the appropriate oversight for the use of psychotropic medications in foster children. As shown by the Illinois experience, a well designed and implemented medication consent and oversight program can improve the quality of care and increase cost-effectiveness.

Again, I want to thank the committee for the opportunity to speak with you today, and I will gladly answer any questions you may have.

Chairman REICHERT. Thank you, Dr. Naylor. You did just fine.

Dr. NAYLOR. Thank you.

Chairman REICHERT. Thank you for your testimony.

[The prepared statement of Dr. Naylor follows:]

INTRODUCTION

Youth in foster care represent a vulnerable population. Most have histories of neglect or physical and/or sexual abuse severe enough to require removal from their homes of origin. Foster children, by definition Medicaid eligible, are at greater risk for developing severe emotional and behavioral disturbances and mental illness,[1,2,3] utilize mental health services at higher rates[3,4,5,6] and are more likely to receive psychotropic medications than other Medicaid eligible youth.[7] In December 2011, the Governmental Accountability Office studied the use of psychotropic medication in foster children in five states during 2008 and reported that foster children were prescribed psychotropic medications at higher rates, were more likely to be treated with five or more concurrent psychotropic medication and were more likely to be prescribed higher than recommended doses of psychotropic medications than nonfoster children in Medicaid.[8]

The use of psychotropic medications to treat foster children with emotional and behavioral disturbances presents unique challenges. Unlike mentally ill children from intact families, youth in state care often do not have a consistent interested party to coordinate treatment planning and clinical care or to provide longitudinal oversight of their treatment. The issues of informed consent and oversight of the utilization of psychotropic medications in this population present a particularly vexing problem. Nationally, child welfare agencies have devised several mechanisms to provide consent for treatment of foster children with psychotropic medications.[9]

In Illinois, the Department of Children and Family Services (DCFS) Office of the Guardian is required by state law to provide consent for all youth for whom they have guardianship.[10] DCFS recognized the need to have a clinically-based quality assurance system to safeguard the medical well-being of its wards and contracted with the University of Illinois at Chicago (UIC) Department of Psychiatry in 1993 to establish the Clinical Services in Psychopharmacology (CSP) to provide an independent review of all psychotropic medication consent requests for foster children to ensure the safety, effectiveness, and appropriateness of the planned treatment regimen. The CSP reviews approximately 14,000 psychotropic medication consent requests and reviews approximately 4,000 emergency medication administrations annually. In addition to reviewing medication requests, the CSP:

1) collects data on the utilization of psychotropic medications in foster children statewide;
2) provides consultation on particularly difficult and/or complex cases;
3) compiles psychotropic medication histories for clinical staffings and administrative case reviews;
4) notifies the DCFS Office of the Guardian and Advocacy when local and/or provider patterns warrant further review and possible remediation;
5) disseminates information on new pharmaceutical developments and alerts to prescribing physicians who serve DCFS wards;
6) drafts materials and reviews and comments on DCFS-developed best practice guidelines and policies and procedures governing the management of psychotropic drugs;
7) partners with DCFS to develop programs to provide evidence-based diagnostic assessments and treatment for high risk children; and
8) develops training materials and conducts training for foster parents, other care providers, and DCFS-identified staff in management of psychotropic medications.

I describe the CSP and present data to demonstrate its effectiveness at monitoring clinical trends and adverse effects of psychotropic medications prescribed to foster children and to assess the program's

impact on psychotropic medication prescribing patterns. In Study 1 we looked at potential risk factors for placement disruption for preschool-aged children. In Study 2 we hypothesized that the rate of consent requests for fluoxetine would increase while the rates of other SSRIs would decrease when the CSP endorsed the use of fluoxetine over other SSRIs. In Study 3 we examined the effect of the psychotropic medication review process on the practice of antipsychotic polypharmacy. In Study 4 we hypothesized that atypical antipsychotic medications would cause weight gain and that gender, race and placement would all affect weight gain. In the Discussion, we describe the implications of these findings, describe their impact on policy and program development and discuss their impact on prescriber practice.

METHODS

Physicians or advanced practice nurses wishing to start a foster child on psychotropic medications must submit consent requests to DCFS. Information submitted includes the child's name, DCFS identification number, date of birth, race, height, weight, diagnoses, target symptoms, relevant medical history, current medications, placement, name and dosage of the requested medication(s), clinician's name, and specialty. The requests are forwarded to the CSP where the information is reviewed by a psychiatric nurse and entered into a database. Consent requests are triaged to one of four board-certified child psychiatrist consultants who review every request. The consultant recommends to DCFS that the request be approved; modified (approved at a different dosage, duration, or administration schedule); or denied. The consultant may request additional information in order to make the recommendation. The completed recommendation is then forwarded to DCFS who formally consents to or denies the medication trial.

Other data sources

The CSP has an interagency agreement with the Illinois Department of Healthcare and Family Services, administrator of the state Medicaid program, to obtain data on claims for all psychiatric services including psychiatric hospitalizations and outpatient visits rendered to foster children and claims for all psychotropic medications prescribed to Illinois foster children. The Medicaid payment database includes recipient name and recipient identification number; brand and generic name and National Drug Code; number of psychotropic medications dispensed; prescription date and quantity dispensed; name, ID number, and specialty of the prescriber; diagnosis and ICD – 9 diagnostic code; and admission and discharge dates of psychiatric and medical hospitalizations.

IRB approval was continuously granted for this project from 2005 through 2014 under UIC protocol 2005-0366.

Study 1

Three hundred-nine foster children born between 01/01/2006 and 12/31/2011 and less than six years of age on 12/31/2011 were included in this study. To be included in this study wards had to have received consent for at least one psychotropic medication from DCFS during the study period of 01/01/2006 and 12/31/2011. Fifty-four were excluded from the study because they had been adopted or had returned to their biological families so their placement histories were not available.

Placement disruption, the primary outcome measure (dependent variable), was defined as ≥ 2 placement changes during the study period. Based on a preliminary examination of our data, we identified children on two or more psychotropic medications, children who have been hospitalized, children with history of physical abuse, children with history of sexual abuse, children with psychotic symptoms like hallucinations, children with risky behaviors such as physical and/or verbal aggression, elopement, property destruction, children with mood dysregulation symptoms such as mood instability, children with attention deficit and/or impulsivity, children with depression and/or anxiety, children with disruptive behaviors and last children who had problems with functioning such as school suspension, sleep problems, bedwetting/enuresis as being at high-risk for placement instability.

Backward elimination in multivariate logistic regression modeling was employed to estimate the association between placement disruption and the independent variables. Bayes law was used to calculate the sensitivity and specificity of statistically significant independent variables independently and in combination.

Study 2

Endorsement of fluoxetine

Based on data from clinical trials and post-marketing, the FDA recommended in 2003 that physicians not use paroxetine for children and adolescents due to lack of evidence of efficacy and an increased risk of suicidal behavior.[31] In September 2003 the CSP consultation team began to issue the following statement when a SSRI (except fluoxetine) was requested for the treatment of child depression:

What is the rationale for choosing _____ over fluoxetine? 1) Fluoxetine, but not _____ has been shown to be more effective than placebo in the treatment of pediatric depression. 2) fluoxetine has favorable safety profile with a low likelihood of inducing suicidal ideation. 3) according to the FDA meta-analysis fluoxetine has a low likelihood of treatment emergent agitation and hostility. 4)

the FDA has approved fluoxetine, but not _____ for the treatment of depression in children and adolescents, and 5) fluoxetine is available as a generic.

In March 2004 the FDA issued a public health advisory warning prescribers of possible increases in suicidal behavior associated with the use of selective serotonin reuptake inhibitors in youth.[12]

We used data from the CSP's database to identify all wards with a depressive or mood disorder. Then we determined the monthly number of consent requests for each SSRI antidepressant and grouped them into three categories: fluoxetine, paroxetine, and other SSRIs. This number was divided by the total number of requests for the month to indicate rate of request for SSRIs. Using SPSS 15.0 we performed time-segmented regression analysis to determine the change in rates between August 1998 and June 2008.

The modified regression lines were based on three time points that affected the prescription rate of antidepressants: the FDA paroxetine warning, the beginning of the CSP endorsement of fluoxetine, and the FDA black box warning. Best fit regression models were determined by backward elimination, reducing a model until all factors (Constant – intercept, Time – slope, Paroxetine Intervention – intercept, Time after Paroxetine Intervention – slope, CSP Intervention – intercept, Time after CSP Intervention – slope, Black Box Intervention – intercept, Time after Black Box Intervention – slope, and a seasonal variable) were significant at $p<.05$. We also performed time-segmented regression on the rate of requests for stimulants in this population to determine if the CSP intervention had a targeted effect on SSRIs rather than a global effect.

Study 3

In FY 2005 we undertook an effort to decrease the use of antipsychotic polypharmacy (the concurrent use of two or more antipsychotics). A policy was implemented to require at least two adequate monotherapy trials, as defined by adequate dosage of the medication and duration of the trial, and one typical neuroleptic trial before polypharmacy would be considered. In addition, the use of antipsychotic medications to treat insomnia was disallowed. Low dose (≤ 100 mg) bedtime trials of quetiapine, a second generation antipsychotic medication, was approved for only limited periods of time (3 – 10 days). The rate of antipsychotic polypharmacy was defined as the percentage of children on one or more antipsychotic medications that were on two or more. Rates of antipsychotic medications were compared for the 0 – 6, 7 – 11, and 13 – 17 year old age groups and for all children 0 – 17 years between FY 2005 and FY 2012.

Study 4

Subjects' medication payment histories were matched by recipient identification number (RIN) to consent information in the CSP database from July 1998 to June 2007, and subsequently de-identified. Records were excluded if the child was 18 years of age or older at the date of the prescription, if the RIN was missing, or if the RIN did not match a child the CSP database.

A medication trial was defined as starting on the date the prescription was first filled and ending 30 days after the last prescription refill. In order to be included in the sample the child must have, at some point, received a psychotropic medication. Patients who had an antipsychotic trial within the 90 days prior to the first antipsychotic trial in the Medicaid claims database were excluded from the study. To be considered a valid trial with continuous use of the medication, there could be no gaps greater than 60 days between refills of the same medication and there must have been at least three recorded weights during the trial. During the course of the study, if a patient had multiple trials of antipsychotic treatment, only the first valid trial was used in the analysis.

In addition to absolute weight change, we studied age- and gender- corrected changes in body weight (z-score). Weight measurements were converted into z-scores using the gender specific Center for Disease Control growth norms.[13] Weight values with z-scores below -3 and above +3, were evaluated in relationship to weight curves for the specific subject, and all were excluded as errors.

As most subjects included in the final analysis were either Black or White, we excluded subjects in other race categories.

Data was analyzed using SPSS software. Chi-square tests were performed to look for significant differences between placement, age, gender, and race in subjects taking different SGAs. Placement, either foster care or in residential treatment, was assigned based on the placement for which the subject had the most data points in the CSP database. For the purpose of this analysis, hospitalization was not considered a placement.

Baseline weight was defined as the weight obtained immediately preceding, less than 90 days prior to, the medication trial. The maximum weight recorded during the drug trial represented the peak weight gain.

We analyzed age in 3 categories: preschool (0-6 years), prepubertal (7-12 years), and pubertal (13-17 years). Race was split into 6 categories: Black, White, Hispanic, Native American, Asian or Pacific Islander, and unknown. Antipsychotics studied included ziprasidone, quetiapine, olanzapine, risperidone, and aripiprazole. Clozapine had insufficient data for analysis.

In order to evaluate weight gain by drug, we used a paired t-test to compare baseline weight with peak weight. To rank the medications, we did pair-wise comparison of SGAs adjusted by demographic variables of age, gender, race, and placement. We determined risk factors for weight gain by performing an ANCOVA analysis with age, race, gender, placement, and SGA as factors and baseline weight as a covariate.

RESULTS

Study 1

The final study sample consisted of 255 children; 72% were male, 47% were white, 46% were African American and 7% were other (Hispanic, biracial, unknown). Fifty-one percent (n = 37) of females experienced placement disruption as compared to 46% (n = 85) of males. Approximately 50% of African Americans experienced placement disruption as compared to 48% (n = 56) of Caucasian children and 33% (n = 6) of Other.

Statistically significant risk factors of placement disruption were: polypharmacy, psychiatric hospitalization, physical and sexual abuse. Table 1 depicts the respective β estimates, odds ratios and their p-values of the four risk factors that were identified in this research study.

Risk factor	β estimate	Odds ratio estimate OR (95% confidence interval)	*p*-value
Intercept (β_0)	-1.35		<0.0001
Polypharmacy	0.66	1.93 (1.1 - 3.5)	0.027
Psychiatric Hospitalization	0.92	2.5 (1.2 - 5.3)	0.016
Physical Abuse	0.99	2.7 (1.3 - 5.3)	0.004
Sexual Abuse	0.63	1.87 (1 - 3.5)	0.05

Table 1: Risk factors for placement disruption

The best combination of risk factors identified in this study for the purpose of a brief screening measure to identify children at risk for placement disruption measure was polypharmacy combined with psychiatric hospitalization. The sensitivity and specificity of this combination was 50.7% and 70.2% respectively.

Study 2

We found that fluoxetine consent requests significantly decreased before the CSP statement but increased significantly afterward. The fluoxetine request rate continued to rise after the FDA black box warning. In contrast, other SSRI rates rose significantly before the intervention and fell steadily afterward Requests for paroxetine declined from the start of the study period and then dropped dramatically after the paroxetine warning.

After the CSP intervention the decline accelerated until the proportion of requests neared zero. Adjusted R^2 for fluoxetine, paroxetine, and other SSRIs were 0.79, 0.92, and 0.79, demonstrating that the regression lines are a very good fit to the data (see Figure 1).

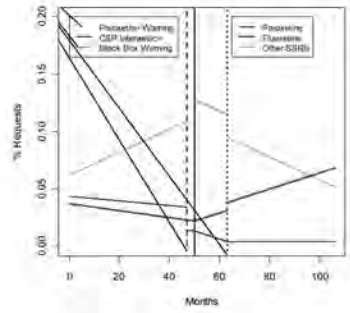

Figure 1: The reduced regression model of rate of change in the request of fluoxetine, paroxetine, and other SSRIs.

Study 3

As a result in the change in policy, there was a 48% decrease in the rate of antipsychotic polypharmacy in all ages from FY 2005 to FY 2012. Particularly large decreases were seen in the 0 – 11 year age groups [45 (4.7%) to 9 (1.1%)], a 77% decline (see Table 2).

	FY 2005		FY 2012	
Age	Any antipsychotic	≥ 2 antipsychotics	Any antipsychotic	≥ 2 antipsychotics
0 - 6	94	2 (2.1)	49	0 (0)
7 - 11	866	43 (5.0)	735	9 (1.2)
13 - 17	1476	164 (11.1)	1239	83 (6.7)
Total	2,436	209 (8.6)	2,023	92 (4.5)

Table 2: Rate of antipsychotic polypharmacy in FY 2005 and FY 2012

Study 4

Using a paired t-test, we compared the baseline weight and peak weight by drug. We found that all 5 antipsychotics caused significant weight gain in both weight and z-score (all $p < 0.0002$). Weight gain in both raw weight and z-score has the same pattern, with olanzapine causing the most weight gain, followed by risperidone, quetiapine, aripiprazole, and ziprasidone. Using a pair-wise comparison of change in z-score, olanzapine caused the most weight gain (all $p < 0.05$) followed by risperidone (all $p<.05$). There was no significant difference in weight gain between quetiapine, aripiprazole and ziprasidone.

In order to determine risk factors for weight gain we performed an ANCOVA analysis with change in z-score as the outcome variable. Due to baseline significant differences in weight, baseline z-score was used as a covariate, and age, gender, race, and placement were used as factors. When baseline weight, demographics, and prescribed antipsychotic were controlled for, gender and placement remained as significant factors. Females gained more weight than males ($p = 0.003$), while youth in residential settings gained more than youth in foster care settings ($p < 0.0001$).

Medication (n)	Weight lb (S.D.)	D weight (S.E.)	Z-score (S.D.)	D Z-score (S.E.)
Risperidone (654)				
Baseline	92.5 (43.0)	25.1 (1.02)[1]	0.32 (1.09)	0.64 (0.03)[1]
Peak	117.6 (52.4)		0.96 (1.07)	
Olanzapine (168)				
Baseline	95.9 (40.4)	29.8 (2.1)[1]	0.27 (1.02)	0.88 (0.07)[1]
Peak	125.7 (49.4)		1.15 (0.85)	
Quetiapine (282)				
Baseline	119.1 (47.5)	21.4 (1.49)[1]	0.73 (1.06)	0.46 (0.04)[1]
Peak	140.5 (51.9)		1.19 (1.04)	
Aripiprazole (158)				
Baseline	123.3 (48.2)	19.5 (1.77)[1]	0.83 (1.21)	0.42 (0.06)[1]
Peak	142.8 (54.0)		1.25 (1.02)	
Ziprasidone (125)				
Baseline	136.6 (51.8)	16.81 (2.04)[1]	1.10 (1.09)	0.23 (0.06)[2]
Peak	153.4 (53.7)		1.33 (1.05)	

[1] – $p < 0.0001$
[2] – $p = 0.0002$

Table 3: Peak weight gain as compared to baseline weight gain

DISCUSSION

We have shown that a prospective psychotropic medication consent and oversight process can result in higher quality and potentially more cost effective care. Based on the findings described above, DCFS has:

- designed and implemented a program that provides specialty evaluations of and evidence-based psychosocial treatments for preschool-aged children in an effort to decrease placement disruption and decrease reliance on psychotropic medications in this age-group.
- increased adherence to evidence-based prescribing for the treatment of pediatric depression. While we do not have outcome data to assess the effectiveness of this strategy, this has resulted in increased use of off-patent medications and decreased the use of non-FDA approved brand name medications. Presumably this has resulted in a cost savings. Using data now available, we will be able to examine this going forward.

- substantially decreased the concurrent prescription of two or more antipsychotic medications. While we have not analyzed the health impact of the use of antipsychotic polypharmacy, we anticipate that the rate of obesity and of the metabolic syndrome and Type II diabetes will decrease. Additionally, it is likely that the decreased use of antipsychotic medications has resulted in a substantial cost savings. Again, using data now available, we will be able to examine these going forward.
- improved the monitoring of adverse effects of psychotropic medications, for example, documenting the extent of weight gain that accompanies the use of second generation antipsychotics. DCFS has written and implemented a policy linking consent for second generation antipsychotics to effective medication monitoring strategies.

Though we do not have data supporting these contentions, anecdotal evidence suggests that the prospective psychotropic medication consent and oversight has:

- improved continuity of care for these high risk youth, preventing the use of medications that have proved ineffective in previous trials or that have resulted in significant adverse effects.
- improved safety of pharmacotherapy through the prevention of potentially serious, even fatal, drug interactions.

In 2008, Congress passed and the president signed into law Public Law 110-351, ''Fostering Connections to Success and Increasing Adoptions Act of 2008''.[14] The law requires that state Medicaid agencies and state child welfare agencies provide ongoing coordination of medical and psychiatric services and monitor utilization of medications, including psychotropic medications. This law was amended in 2011 by P.L. 112-34, the "Child and Family Services Improvement and Innovation Act" to require states to outline protocols for the appropriate use and monitoring of psychotropic medications.[15] The Illinois model of providing consent for psychotropic medications for foster children and monitoring the use of these medications is widely regarded as a pioneer and leader in this arena and has received considerable attention. The lessons learned in the development and implementation of the Illinois model for providing consent for psychotropic medications and overseeing the utilization of these medications in foster children can provide valuable guidance to other states as they move to develop similar programs.

As demonstrated by the Illinois experience, a well-designed and implemented medication consent and oversight program that provides effective longitudinal oversight of a youth's care and monitoring of prescribing patterns can improve the continuity and quality and increase the cost-effectiveness of care provided to foster children. Anticipated benefits of the consultation and educational services for foster parents, childcare workers, and caseworkers include increased placement stability and reduced need for psychiatric hospitalization.

Acknowledgements and Disclosures

This research was supported by an Illinois Department of Children and Family Services contract. I have served as a consultant to the Governmental Accountability Office for two studies on the use of psychotropic medications in foster children. I have also consulted with Michigan and Maryland as they developed their psychotropic medication oversight programs. I would like to thank the staff of the

DCFS Centralized Psychotropic Medication Consent Line and the Clinical Services in Psychopharmacology Program for their role in collecting data.

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Chairman REICHERT. Mr. Lord, you are recognized for 5 minutes.

STATEMENT OF STEPHEN LORD, DIRECTOR, FORENSIC AUDITS AND INVESTIGATIVE SERVICES, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

Mr. LORD. Thank you, Chairman Reichert, Ranking Member Doggett, and other distinguished Members of the Committee. I am really honored to be here on this distinguished panel to discuss GAO's work examining the use of psychotropic medications in the foster children community. As we have already heard today, foster children are an especially vulnerable population, and in 2012, there were over 400,000 children in the foster care system, some of whom had experienced neglect and physical abuse.

Today I would like to focus on two key issues. The first is the extent to which children in foster care are prescribed psychotropic medications, and secondly, Federal and State oversight of these practices. The first key point I would like to make is that children in foster care take psychotropic medications at higher rates than other children. As we heard from the administration witness, 18 percent of foster children were taking a psychotropic medication at the time they were surveyed, and this compares to about 6 percent for noninstitutionalized children in Medicaid nationwide and about 5 percent for children in private insurance plans.

It is also important to note that within certain populations of foster children, for example, those who lived in group homes or residential treatment centers, the rates are much higher. The data shows that 48 percent of those living in residential homes and treatment centers were taking psychotropic medications.

But another important caveat is these rates do not necessarily imply inappropriate prescribing practices based on the medical experts we consulted. In some cases, these rates could be due to foster children's greater mental health needs and perhaps greater exposure to trauma.

The second key point I would like to make is the Federal and State oversight of psychotropic use among foster children has improved over the last few years, although we wholeheartedly agree additional guidance and attention is needed. In 2011, we reported that States monitoring psychotropic use among foster children fell short of the best practice guidelines espoused by the American Academy of Child and Adolescent Psychiatry. Thus we recommended that HHS endorse additional best practice guidance to help ensure States were properly overseeing the use of these drugs. And the good news is that HHS agreed with our recommendation, and ACF has issued directives to States to establish better protocols for monitoring their youth, and this includes a key April 2012 program of instruction designed to achieve this goal.

However, as we highlighted in our new report we issued just last week, additional guidance is needed, as some States transition away from the so-called fee-for-service arrangement to managed care organizations to deliver these prescription drug benefits. The need for additional guidance is underscored also by our detailed case study reviews, the 24 case studies we did as part of our current work. In some instances, the experts we consulted, including

Dr. Naylor, I should point out, found good supporting documentation in the case files for the youth. However, in other areas, there was a question. You know, we found some supporting documentation, but it raised questions about whether some children were receiving the proper therapies and treatments, such as evidence-based therapies that might have been useful.

In closing, Federal and State governments have actively taken a number of important steps to better oversee the prescribing of these drugs. That is the key message of the body of work GAO has issued in this area, but as we recently highlighted, additional steps are needed to help ensure there is good oversight and monitoring of this drug use.

Mr. Chairman, that concludes my statement. I look forward to answering any questions you may have. Thanks.

Chairman REICHERT. Thank you, Mr. Lord.

[The prepared statement of Mr. Lord follows:]

GAO Highlights

Highlights of GAO-14-851T, a testimony before the Subcommittee on Human Resources, Committee on Ways and Means, House of Representatives

May 29, 2014

FOSTER CHILDREN

HHS Could Provide Additional Guidance to States Regarding Psychotropic Medications

Why GAO Did This Study

Foster children have often been removed from abusive or neglectful homes and tend to have more mental-health conditions than other children. Treatment of these conditions may include psychotropic drugs, but the risks these drugs pose specifically to children are not well understood. This testimony discusses GAO's recent work on (1) the extent to which children in foster care are prescribed psychotropic medications, (2) federal and state actions to oversee psychotropic prescribing to children in foster care, and (3) the extent to which the use of psychotropic medications was supported by foster and medical records for selected case studies of children in foster care who were prescribed these medications. This testimony is based on previous GAO reports issued from 2011 through 2014 that used various methodologies, including reviewing federal studies, analyzing Medicaid prescription claims data from five states, and contracting with two experts to review 24 case files (selected, in part, based on potential health risk indicators). The findings related to the expert reviews of 24 case files are not generalizable.

What GAO Recommends

GAO has made recommendations in prior work, including that the Secretary of Health and Human Services issue guidance to state Medicaid, child-welfare, and mental-health officials regarding prescription-drug monitoring and oversight for children in foster care receiving psychotropic medications through MCOs. The Department of Health and Human Services (HHS) concurred with the recommendation and described planned actions.

View GAO-14-851T. For more information, contact Stephen Lord at (202) 512-6722 or lords@gao.gov or Katherine Iritani at (202) 512-7114 or iritanik@gao.gov.

What GAO Found

In December 2012, GAO reported on the results of the Administration for Children and Families (ACF) surveys of children in contact with the child-welfare system conducted during 2008-2011. 18 percent of foster-care children were taking a psychotropic medication at the time they were surveyed. Foster children who lived in group homes or residential treatment centers had much higher rates of psychotropic medication use than those living in nonrelative foster homes or formal kin care—48 percent versus 14 percent and 12 percent, respectively, according to the surveys. The higher utilization rate among children living in group homes or residential treatment centers may be related to these children having higher rates of potential mental-health need. Among foster children who took psychotropic medication, about 13 percent took three or more psychotropic medications concurrently. About 6.4 percent of foster children took an antipsychotic medication—psychotropic medications with potentially serious side effects that are intended to treat serious mental-health conditions such as schizophrenia—and the majority were ages 6 -11. In examining prescribing at the state level, GAO found similar results in its December 2011 review. Specifically, children in foster care in Florida, Massachusetts, Michigan, Oregon, and Texas were prescribed psychotropic medications at higher rates than nonfoster children in Medicaid during 2008, although prescribing rates varied by state.

In April 2014, GAO found the federal government and states have taken a multitude of steps to better oversee psychotropic drug prescribing for children in foster care, although more can be done as states increasingly deliver their medication benefits through Medicaid managed care. In addition, GAO found that, to varying degrees, each of the five selected states it reviewed had policies and procedures designed to address the monitoring and oversight of psychotropic medications prescribed to children in foster care. For example, all five selected states' foster-care programs use a screening tool that may prompt a referral of the foster child for a psychiatric evaluation. GAO also found that ACF had provided webinars and technical guidance to states. However, many states have, or are transitioning to, managed care organizations (MCO) to deliver Medicaid prescription-drug benefits, and GAO found variation in the extent that the five selected states were taking steps to plan for the oversight of drug prescribing for foster children receiving these benefits through MCOs.

For an April 2014 report, GAO contracted with two child psychiatrists to review foster and medical records for 24 cases in five selected states and found varying quality in the documentation supporting the use of psychotropic medications for children in foster care. These experts found that for many of the cases the prescriptions were mostly supported by documentation. However, in some areas, such as evidence-based therapies—interventions shown to produce measureable improvements—the experts found documentation was lacking. For example, the experts found that 3 of 15 children who may have benefited from such therapies were mostly provided such services, while in 11 of the 15 cases, the experts found that evidence-based therapies were partially provided but also found that other evidence-based therapies that may have been more applicable or beneficial were not provided, based on the documents reviewed. In 1 of the 15 cases there was no documentation that evidence-based therapies were provided.

Chairman Reichert, Ranking Member Doggett, and Members of the Subcommittee:

I am pleased to be here today to discuss our work examining the use of psychotropic drugs among children in foster care. Child mental-health advocates, providers, and researchers have expressed concerns about the increase in the prescribing of psychotropic medications (medications that affect mood, thought, or behavior) for children, in part because there is limited evidence available regarding short- and long-term safety and efficacy for some types of medications, particularly for combinations of these medications. Mental-health experts are especially concerned about the recent increase in the prescribing of antipsychotic medications—psychotropic medications that are intended to treat serious mental-health conditions such as schizophrenia and bipolar disorder—in part because these medications can cause serious side effects, such as rapid weight gain and the development of diabetes. Concerns about the increased prescribing of psychotropic medications may be compounded for children in foster care, who may be at higher risk of mental-health conditions than other children. Children in foster care are an especially vulnerable population because often they have been subjected to traumatic experiences involving abuse or neglect and they may suffer from multiple, serious mental-health conditions.[1]

Early detection and treatment of mental-health conditions can improve a child's symptoms and reduce potentially detrimental effects, such as difficulties with relationships, dropping out of school, and involvement with the juvenile justice system. Children with mental-health conditions, such as attention deficit hyperactivity disorder (ADHD) or depression, can be treated with psychosocial therapies (sessions with a provider designed to reduce symptoms and improve functioning); psychotropic medication; or a combination of both.

Several agencies in the Department of Health and Human Services (HHS) have responsibilities related to children's mental-health. The

[1]According to the Administration for Children and Families (ACF), 46 percent of children investigated by child welfare services came to the state's attention because of a report of neglect, and 27 percent had experienced physical abuse as the most serious form of maltreatment. See U.S. Department of Health and Human Services, Administration for Children and Families, National Survey of Child and Adolescent Well-Being (NSCAW), No. 7, *Special Health Care Needs Among Children in Child Welfare* (Washington, D.C.: Jan. 15, 2007).

Administration for Children and Families (ACF) provides funding for and oversees states' child-welfare programs, which are responsible for monitoring and coordinating mental-health services for children in foster care, among other things. The Centers for Medicare & Medicaid Services (CMS) oversees, and jointly finances with the states, the Medicaid program, which provides health coverage to most children in foster care.[2] State Medicaid programs are required by federal law to provide coverage for certain health services, which may include mental-health services, for children through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. The Substance Abuse and Mental Health Services Administration (SAMHSA) works to increase the quality and availability of mental-health services, such as by awarding grants that support the development of community-based services for children with mental-health conditions, including children in foster care.

My testimony today relates to the use of psychotropic drugs among children in foster care. Specifically, my remarks will focus on three areas:

- the extent to which children in foster care are prescribed psychotropic medications;
- federal and state actions to oversee psychotropic medication prescribing to children in foster care; and
- results from reviews of selected case studies of children in foster care who were prescribed these medications.

My statement is based on our previously issued reports, issued from December 2011 to April 2014, related to psychotropic medication prescribing among foster care children.[3] For this prior work, among other things, we described the results of ACF's National Survey of Child and Adolescent Well-being II (NSCAW II), a nationally representative

[2]Medicaid is a joint federal-state program that finances health-care coverage for certain low-income individuals.

[3]See GAO, *Foster Children: HHS Guidance Could Help States Improve Oversight of Psychotropic Prescriptions*, GAO-12-201 (Washington, D.C.: Dec. 14, 2011); *Children's Mental Health: Concerns Remain about Appropriate Services for Children in Medicaid and Foster Care*, GAO-13-15 (Washington, D.C.: Dec. 10, 2012); and *Foster Children: Additional Federal Guidance Could Help States Better Plan for Oversight of Psychotropic Medications Administered by Managed-Care Organizations*, GAO-14-362 (Washington, D.C.: Apr. 28, 2014). Each of these products contains detailed information on the various methodologies used in our work.

longitudinal survey of children ages 0 through 19 who were in contact with the child welfare system.[4] In addition, we analyzed 2008 Medicaid prescription drug claims and foster care data for five states (Florida, Massachusetts, Michigan, Oregon, and Texas), and contracted with two child psychiatrists to provide clinical evaluations of 24 cases.[5] The case selections were based, in part, on potential health risk indicators identified by experts. The cases cannot be generalized to the foster-care population. The reports cited in this statement each provide detailed information on our scope and methodology.

The work on which this statement is based was conducted in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our audit findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Children enter state foster care when they have been removed from their parents or guardians and placed under the responsibility of a state child-welfare agency. At the end of fiscal year 2012, approximately 400,000 children were living in foster care, mostly as a result of having experienced neglect or abuse by their parents.[6] When children are taken into foster care, the state's child-welfare agency becomes responsible for determining where the child should live and providing the child with needed support. The agency may place the foster child in the home of a relative, with unrelated foster parents, or in a group home or residential

[4]GAO-13-15; the NSCAW II surveys occurred in multiple phases during 2008 through 2011. See Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, *NSCAW II Baseline Report: Children's Services*, OPRE Report #2011-27f (Washington, D.C.: 2011) and Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, *Psychotropic Medication Use by Children in Child Welfare*, OPRE Report #2012-33 (Washington, D.C.: 2012).

[5]GAO-12-201; GAO-14-362.

[6]These are the most recent data available. See U.S. Department of Health and Human Services, *The AFCARS Report, Preliminary FY 2012 Estimates as of July 2013*, No. 20. (Washington, D.C.: November 2013).

treatment center, depending on the child's needs.[7] The agency is also responsible for arranging needed services, including mental-health services. Coordinating mental-health care for children in foster care may be difficult for both the medical provider and the caseworker depending on the complexity of the child's needs, and because multiple people are making decisions on a child's behalf. In addition, caseworkers in child-welfare agencies may have large caseloads, making it difficult for them to ensure each child under their authority receives adequate mental-health services.

In 2011, the Child and Family Services Improvement and Innovation Act amended the Social Security Act to require states to identify protocols for monitoring foster children's use of psychotropic medications and to address how emotional trauma associated with children's maltreatment and removal from their homes will be monitored and treated.[8] ACF requires states to address these issues in their required Annual Progress and Services Reports (APSR) and has provided guidance detailing how states are to address protocols for monitoring foster children's use of psychotropic medications as part of the state's APSR.[9] Among other things, state monitoring protocols are to address

- screening, assessment, and treatment planning to identify children's mental-health and trauma-treatment needs, including a psychiatric evaluation, as necessary, to identify needs for psychotropic medications;
- effective medication monitoring at both the client and agency level; and
- informed and shared decision making and methods for ongoing communication between the prescriber, the child, caregivers, other health-care providers, the child-welfare worker, and other key stakeholders.

[7]Group homes and residential treatment centers provide 24-hour care in a group setting to children with physical or behavioral needs. Residential treatment centers are inpatient facilities other than a hospital that provide specialized services to children, such as psychiatric services.

[8]Child and Family Services Improvement and Innovation Act, Pub. L. No. 112-34, § 101(b)(1) and (2), 125 Stat. 369 (amending 42 U.S.C. § 622(b)(15)(A)).

[9]See U.S. Department of Health and Human Services, Administration for Children and Families, Program Instruction ACYF-CB-PI-12-05 (Washington, D.C.: Apr. 11, 2012).

According to ACF, child-welfare systems that choose to pursue comprehensive and integrated approaches to screening, assessing, and addressing children's behavioral and mental-health needs—including the effects of childhood traumatic experiences—are more likely to increase children's sense of safety and provide them with effective care.

Children in foster care who are enrolled in Medicaid may receive services generally through one of two distinct service-delivery and financing systems—managed care or fee-for-service. Under a managed-care model, states may contract with a managed-care organization (MCO) and prospectively pay the MCO a fixed monthly fee per patient to provide or arrange for most health services, which may include prescription-drug benefits. The MCOs, in turn, pay providers. In the traditional fee-for-service delivery system, the Medicaid program reimburses providers directly and on a retrospective basis for each service delivered.

Children in Foster Care Receive Psychotropic Medications at Higher Rates than Other Children in Medicaid

In December 2012, we reported information on national levels of psychotropic drug use among foster care children based on the results of the NSCAW II.[10] According to the results from NSCAW II, 18 percent of foster-care children were taking a psychotropic medication at the time they were surveyed.[11] Additionally, foster children who lived in group homes or residential treatment centers had much higher rates of psychotropic medication use than foster children living in nonrelative foster homes or formal kin care—48 percent versus 14 percent and 12 percent, respectively.[12] The higher utilization rate among children living in group homes or residential treatment centers may be related to these children having higher rates of potential mental-health need—about 69

[10]GAO-13-15.

[11]In the survey, caregivers were asked whether the child was currently taking a psychotropic medication. Estimates for foster children refer to those who lived in nonrelative foster homes, formal kin care, group homes, or residential treatment centers.

[12]Based on data that ACF reported, about 50 percent of foster children lived in nonrelative foster homes, 41 percent lived in formal kin care arrangements, and 9 percent lived in group homes or residential treatment centers. U.S. Department of Health and Human Services, *Psychotropic Medication Use by Children in Child Welfare*, 2. Formal kin care is a living arrangement where the child is placed under legal custody of the state, but in physical custody of a relative. Differences in medication utilization by living arrangement are statistically significant and are based on NSCAW II phase 1 data (collected during March 2008 through September 2009). U.S. Department of Health and Human Services, *NSCAW II Baseline Report: Children's Services*, 45–46.

percent had a potential mental-health need compared to about 44 percent of children living in nonrelative foster homes.[13] Another study found that child welfare workers were more likely to place children with behavior problems in a group-living arrangement than with a foster family.[14] NSCAW II data showed that 30 percent of foster children with a potential mental-health need had not received any mental-health services, such as treatment at an outpatient mental-health center or with a mental-health professional or family doctor, within the previous 12 months or since the start of the child's living arrangement, if less than 12 months.[15]

In December 2012 we also found that in addition to reporting on overall use of psychotropic medications, the NSCAW II included information on concurrent use of psychotropic medications and on the use of antipsychotics by foster children. Among foster children who took psychotropic medication, 13 percent took three or more psychotropic medications concurrently.[16] The American Academy of Child & Adolescent Psychiatry (AACAP) has noted that there is a lack of research on the efficacy of taking multiple psychotropic medications concurrently. NSCAW II survey findings also showed that 6.4 percent of foster children took an antipsychotic medication and that the majority were ages 6 through 11.[17] Mental-health researchers and others have stated that there

[13]ACF's reports identified children with a potential mental-health need by selecting children whose scores were above a certain level on one of five standardized psychometric scales that were used in NSCAW II and were designed to measure emotional or behavioral problems. According to ACF, these scales are reliable assessments of children's behavioral and emotional problems.

[14]M. E. Courtney, "Correlates of Social Worker Decisions to Seek Treatment-Oriented Out-of-Home Care," *Children and Youth Services Review*, vol. 20, no. 4, (1998).

[15]Estimates of children with potential mental-health need who had not received mental-health services are based on NSCAW II phase 2 data (collected during October 2009 through January 2011). U.S. Department of Health and Human Services, *Psychotropic Medication Use by Children in Child Welfare*, 6.

[16]Estimates of concurrent use are based on NSCAW II phase 2 data (collected during October 2009 through January 2011). This estimate does not include children in formal kin care. U.S. Department of Health and Human Services, *Psychotropic Medication Use by Children in Child Welfare*, 4.

[17]Estimates of antipsychotic use are based on NSCAW II phase 2 data (collected during October 2009 through January 2011). This estimate does not include children in formal kin care. U.S. Department of Health and Human Services, *Psychotropic Medication Use by Children in Child Welfare*, 4.

is a need for further research on the safety and effectiveness of antipsychotics for children, particularly the long-term effects.

In December 2011, we reported findings from our analysis of five states' Medicaid prescription drug data that found children in foster care in Florida, Massachusetts, Michigan, Oregon, and Texas were prescribed psychotropic medications at higher rates than nonfoster children in Medicaid during 2008.[18] Specifically, we found that among these states foster children were prescribed psychotropic drugs at rates 2.7 to 4.5 times higher than were nonfoster children in Medicaid in 2008. The rates were higher among foster children for each of the age ranges—0 to 5 years old, 6 to 12 years old, and 13 to 17 years old—that we reviewed. According to research, experts we consulted, and certain federal and state officials we interviewed as part of our December 2011 report, this could be due in part to foster children's greater exposure to traumatic experiences, frequent changes in foster placements, and varying state oversight policies.

In our December 2011 report, we also found that prescriptions for foster children in these five states were more likely to have indicators of potential health risks. According to experts consulted, no evidence supports the concurrent use of five or more psychotropic drugs in adults or children, yet an analysis of Medicaid claims data suggested that hundreds of both foster and nonfoster children in these five states had such a drug regimen. Increasing the number of drugs used concurrently increases the likelihood of adverse reactions and long-term side effects, such as high cholesterol or diabetes, and limits the ability to assess which of multiple drugs are related to a particular treatment goal.[19] Similarly, in December 2011 we found that thousands of foster and nonfoster children in Medicaid were prescribed doses higher than the maximum levels cited in guidelines developed by Texas based on FDA-approved product labels

[18]GAO-12-201.

[19]See Julie M. Zito et al., *Psychotropic Medication Patterns Among Youth in Foster Care*, *Pediatrics*, vol.121, no. 1 (2008), 157–163.

or medical literature maximum dosages for children and adolescents.[20] Our experts said that this increases the risk of adverse side effects and does not typically increase the efficacy of the drugs to any significant extent.[21] Further, foster and nonfoster children under 1 year old were prescribed psychotropic drugs, which experts consulted said have no established use for mental-health conditions in infants and providing them these drugs could result in serious adverse effects. These experts also said that the prescriptions could have been prescribed for non-mental-health reasons, such as for seizures, and to treat allergies, itching, or other skin conditions.[22]

[20]Analysis included in our December 2011 report used dosage guidelines developed by the state of Texas based on FDA-approved or medical literature maximum dosages for children and adolescents. ACF lists these guidelines as an example for other states. For additional information, see GAO-12-201 and Texas Department of Family and Protective Services, and the University of Texas at Austin College of Pharmacy, *Psychotropic Medication Utilization Parameters for Foster Children* (Austin, Tex.: December 2010).

[21]The Food and Drug Administration (FDA), within HHS, approves drugs for use for specified indications, and these indications are set forth on the drugs' FDA-approved drug labels.

[22]Experts also noted that some of these prescriptions may have been written with the intention of treating an uninsured parent or sibling. It was not possible to determine from the data whether this was the case.

HHS and States Have Made Progress in Improving Oversight of Psychotropic Prescriptions, but Additional Guidance Could Help Officials Manage Psychotropic Medications

In December 2011, we found that six selected states' monitoring programs for psychotropic drugs provided to foster children fell short of best principles guidelines published by the AACAP.[23] The guidelines, which states were not required to follow at the time of this report, covered four categories.[24] The following describes the extent to which the selected states' monitoring programs in our review covered these areas.

- Consent: Each state had some practices consistent with AACAP consent guidelines such as identifying caregivers empowered to give consent.
- Oversight: Each state had procedures consistent with some but not all oversight guidelines, which include monitoring rates of prescriptions.
- Consultation: Five states had implemented some but not all guidelines, which include providing consultations by child psychiatrists by request.
- Information: Four states had created web-sites about psychotropic drugs for clinicians, foster parents, and other caregivers.

We found that this variation was expected because states set their own guidelines, and, at the time of our 2011 report, HHS had not yet endorsed specific measures for state oversight of psychotropic prescriptions for children in foster care. We recommended that HHS consider endorsing guidance for states on best practices for overseeing psychotropic prescriptions for children in foster care. HHS concurred with the recommendation and, in April 2012, issued guidance regarding the oversight of psychotropic medications among children in foster care. HHS has also undertaken collaborative efforts to provide guidance and promote information sharing among states.

In April 2014, we issued a follow-up report to, among other things, assess HHS actions taken since our 2011 report and describe selected states' policies related to psychotropic medication.[25] In addition to issuing the guidance we recommended, HHS efforts have focused on using mental-

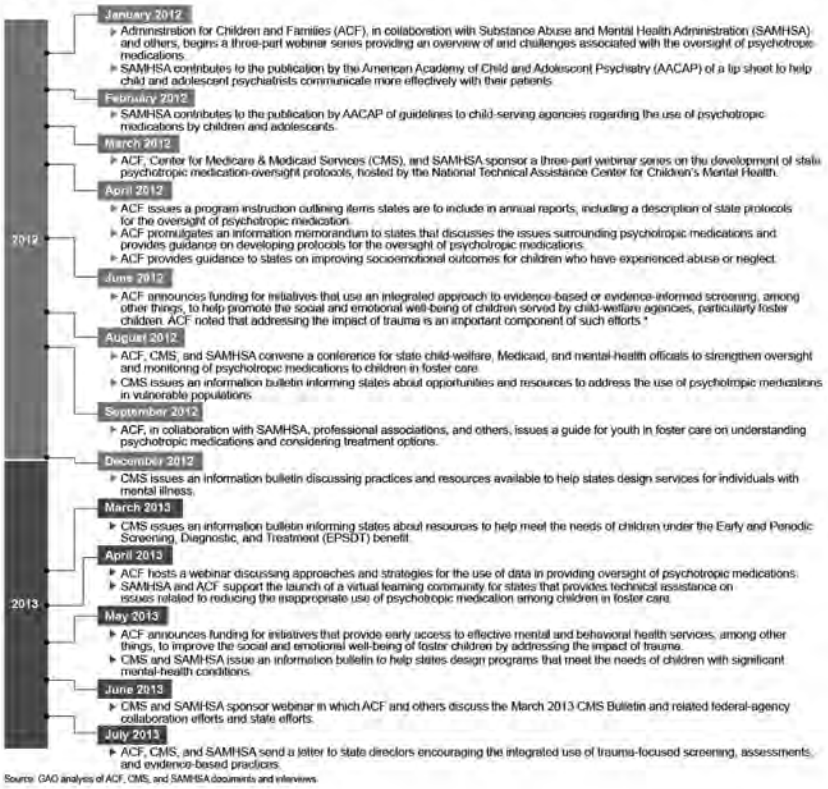
[23]GAO-12-201. The six selected states included Florida, Maryland, Massachusetts, Michigan, Oregon, and Texas.

[24]*AACAP Position Statement on Oversight of Psychotropic Medication Use for Children in State Custody: A Best Principles Guideline*

[25]GAO-14-362

health screening tools and providing therapies that address trauma, which seek to ensure that the mental-health needs of children in foster care are appropriately met. See figure 1 below for a list of initiatives undertaken since our December 2011 report by ACF, CMS, and SAMHSA.

Figure 1: Department of Health and Human Services (HHS) Efforts to Support States' Oversight of Psychotropic Medications among Children in Foster Care and Encourage the Use of Mental-Health Assessments and Screening Tools since December 2011



Source: GAO analysis of ACF, CMS, and SAMHSA documents and interviews.

In our April 2014 follow-up report, we also found that, to varying degrees, each of the five selected states we reviewed has policies and procedures designed to address the monitoring and oversight of psychotropic medications prescribed to children in foster care. For example:

- All five selected states' foster-care programs use some type of functional assessment or screening tool, such as the Child and Adolescent Needs and Strengths (CANS), for screening and treatment planning, which may prompt a referral for a psychiatric evaluation as deemed appropriate.
- All five of the selected states have designed a mechanism to coordinate and share some or all Medicaid prescription claims data with the state's foster-care agency to help monitor and review cases based on varying criteria, such as prescriptions for children under a particular age, high dosages, or concurrent use of multiple medications.

Three of five states—Florida, Massachusetts and Texas—included in our April 2014 review use, or are transitioning from fee-for-service to, MCOs to administer prescription-drug benefits for mental-health medications. Medicaid officials from two of those three states reported that their states had conducted limited planning to ensure appropriate oversight of MCOs administering psychotropic medications.

ACF, CMS, and SAMHSA have developed guidance for state Medicaid, child-welfare, and mental-health officials related to the oversight of psychotropic medications that underscored the need for collaboration between state officials to improve prescription monitoring. However, we found in April 2014 that this guidance does not address oversight within the context of a managed-care environment, in which states rely on a third party to administer benefits such as psychotropic medications. Many states have, or are transitioning to, MCOs to administer prescription-drug benefits, and, as our work demonstrates, selected states have taken limited steps to plan for the oversight of drug prescribing for foster children receiving health care through MCOs—which creates a risk that controls instituted in recent years under fee-for-service may not remain once states move to managed care. In our April 2014 report, we concluded that additional guidance from HHS that helps states prepare and implement monitoring efforts within the context of a managed-care environment could help ensure appropriate oversight of psychotropic medications to children in foster care. We recommended that the Secretary of Health and Human Services issue guidance to state

Medicaid, child-welfare, and mental-health officials regarding prescription-drug monitoring and oversight for children in foster care receiving psychotropic medications through MCOs. HHS concurred with the recommendation and described planned actions to address it, such as having CMS work with other involved agencies to coordinate guidance between CMS and other HHS agencies.

Case Studies Varied in Quality of Documentation Supporting the Use of Psychotropic Medications

Expert Reviews of Select Foster Children's Foster and Medical Files Found Variation in the Quality of Documentation

As part of our April 2014 report, we also contracted with two child psychiatrists to provide clinical evaluations of 24 cases that we selected from the population of foster children prescribed psychotropic drugs in 2008.[26] The case selections were based, in part, on potential health risk indicators, such as concurrent use of five or more psychotropic medications, doses higher than the maximum levels cited in guidelines developed by Texas based on FDA-approved labels or medical literature maximum dosages for children and adolescents, and children less than 1 year old prescribed psychotropic drugs. Our experts' reviews of 24 foster children's foster and medical files in five selected states found that the quality of documentation supporting the prescription of psychotropic medication usage varied with respect to (1) screening, assessment, and treatment planning; (2) medication monitoring; and (3) informed and shared decision making.

Screening, Assessment, and Treatment Planning. Our experts' evaluation of this category included whether medical pediatric exams and evidence-based therapies—which are interventions shown to produce measureable improvements—were provided as needed, according to

[26]GAO-14-362.

records.[27] Our experts found in 22 of 24 cases that medical pediatric exams were mostly supported by documentation. For example, in one case with mostly supporting documentation, experts found that a child with a history of behavioral and emotional problems had records documenting a medical pediatric exam and thorough psychological assessments, with comprehensive discussions of diagnostic issues and medication rationale. With regard to evidence-based therapies, experts found that 3 of 15 children who may have benefitted from such therapies were mostly provided such services. In 11 of 15 applicable cases, the experts found that evidence-based therapies were partially provided, such as for instances when some psychosocial or evidence-based therapies were documented, but other evidence-based therapies that may have been more applicable or beneficial were not provided. In 1 of 15 cases there was no documentation that evidence-based therapies were provided.

Medication Monitoring. Our experts' evaluation of this category included the appropriateness of medication dosage and the rationale for concurrent use of multiple medications, according to records. Our experts found appropriateness of medication dosages was mostly supported by documentation in 13 of 24 cases and partially supported in the other 11 cases. The rationale for concurrent use of multiple medications was mostly supported in 5 of the 20 cases where multiple medications were used, but 14 of 20 cases included documentation that partially supported concurrent use, and 1 case did not include documentation to support concurrent use. For example, in one case with partially supporting documentation, our experts found that a child was prescribed four psychotropic drugs concurrently, when nonmedication interventions could have been considered.

Informed and Shared Decision Making. Our experts' evaluation of this category included whether informed consent and communication between treatment providers occurred, according to records. Our experts found that informed-consent decisions were mostly documented in 5 of 23 applicable cases. In 11 of 23 cases, our experts found partial documentation of informed consent—such as when some, but not all, medications prescribed to the child included documentation of informed

[27]Psychosocial therapies that have been shown to be effective in treating mental-health conditions may be referred to as evidence-based therapies. Trauma-focused cognitive behavioral therapy is an example of an evidence-based therapy.

consent—and 7 other cases did not include any documentation of informed consent. For example, in one case, our experts reported there was no documentation of informed consent, psychiatric evaluation, psychiatric diagnosis, or monitoring of antipsychotic medication. In this case, the child was prescribed an antianxiety medication (buspirone), an antipsychotic medication (risperidone), and an ADHD medication (clonidine) at 4 years of age, presumably to treat psychiatric symptoms that interfered with his functioning, including short attention span, wandering off, self-injury, and aggression. However, our experts noted the documentation was too sparse to determine why the psychotropic medications were prescribed, and the indications, monitoring, and side effects could not be evaluated. In addition, our experts found that communication between treatment providers was mostly documented in 15 of 23 applicable cases. However, communication between treatment providers was partially documented in 5 of 23 cases, and there was no evidence that such communication occurred in 3 of 23 cases. Foster children can experience frequent changes in their living placements, which can lead to a lack of continuity in mental-health care, and new providers may not have the medical history of the patient. [28] This lack of stability can lead to treatment disruptions and can increase the number of medications prescribed.

Some Prescriptions in Infant Cases Were for Non-Mental-Health Reasons, but Others Were for Psychiatric or Unclear Reasons

Of the 24 cases reviewed, 9 were infant cases that our experts evaluated to determine whether the prescriptions were for psychiatric or non-mental-health reasons. Our experts agreed that prescriptions of psychotropic medications to infants carries significant risk as there are no established mental-health indications for the use of psychotropic medications in infants and the medications have the potential to result in serious adverse effects for this age group. Our experts found in 4 of 9 infant cases reviewed that the prescription of psychotropic medication was for non-mental-health purposes, such as to treat skin conditions, based on documentation reviewed. However, our experts found that in 2 of 9 cases the infants were prescribed psychotropic medications for psychiatric

[28]ACF reported that foster children moved an average of 1.6 times in an 18-month period and that some children changed placements as many as 12 times in that same period. See L. F. Stambaugh et al., *Psychotropic Medication Use by Children in Child Welfare*, OPRE Report #2012-33 (Washington, D.C.: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, 2012).

reasons, and the rationale and oversight for such medications were partially supported by documentation. In 3 of 9 infant cases, our experts were unable to discern whether the psychotropic medications were prescribed to infants for mental-health purposes or for some other medical reason, based on documentation reviewed.

In conclusion, early detection and treatment of mental-health conditions can improve a child's symptoms and reduce potentially detrimental effects, such as difficulties with relationships, dropping out of school, and involvement with the juvenile justice system. Despite the need for treatment, child mental-health advocates, providers, and researchers have expressed concern about the increase in prescribing of psychotropic medications for children because of limited information on the safety and efficacy of the medications being prescribed in the child population. Children in foster care are especially vulnerable because they more frequently have been subjected to traumatic experiences involving abuse or neglect and they may suffer from multiple, serious mental-health conditions. Our analysis of national survey data, state Medicaid data, and a sample of case files indicates that concerns raised by providers, advocates, and others about potentially inappropriate prescribing of psychotropic medications for children in foster care may be warranted. The federal government and state governments in our review recently have taken action to improve the oversight of psychotropic medication prescribing to foster care children, however, continued assessment and guidance is needed to protect this vulnerable population.

Chairman Reichert, Ranking Member Doggett, and Members of the Committee, this completes my prepared statement. I would be pleased to respond to any questions that you may have at this time.

Contacts and Acknowledgments

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Chairman REICHERT. Thank you all for your testimony.

We now move into the question and answer phase of the hearing. I will begin.

My first question is for Ms. Hovenier. I just want to thank you again for being here and having courage to tell your story and also thank you for all the work that you are doing to help other children in foster care.

You talked a little bit about how you succeeded and what helped you, and really you focused on people need love; children need love versus drugs. And I wonder if you could just tell me a little bit more about—we know your family was there. They loved you. Your CASA adviser was there. How did you finally get to the point where you were being able to pull yourself out of that or have your family pull yourself out of that treatment center?

Ms. HOVENIER. So, on my 18th birthday, I aged out of foster care. When I turned 18, they could no longer keep me there. However——

Chairman REICHERT. The drugs.

Ms. HOVENIER. In the psychiatric facility, they could no longer keep me there.

Chairman REICHERT. Right.

Ms. HOVENIER. And since I was no longer there, I didn't want to take the medications to start out with, so when I left the facility, I am like, Okay, I am never taking another psychotropic medication because I do not like the way they made me feel, and I have never liked it. And so that was when I decided I don't need the medication. I already knew I didn't need it, but that was the starting point with, Okay, I want to get off; how do I do this? And when I moved up to Bellingham, we couldn't find a psychiatrist to take me off because they looked into my records from the psychiatric facility, and they said that they didn't want to take me off because I was a liability, that I might do something, but they didn't know me before I was on the medication. Before I was on the medication, I was a normal teenager, being a normal rebellious teenager, but apparently, when you are in foster care and you are rebellious, you get medicated. So just having my family, my adopted family and my new family just support me, and they are like, Okay, we want to do what you want to do. We are here. Just let us know anything we can do, and having a private paid therapist was a big deal to me because this therapist knew me and wanted to support me in getting off. And she wasn't one of the therapists that were like, Oh, we are leaving you on this, we want to keep you on this. So I think that was a big difference.

Chairman REICHERT. How do you think we can help other foster kids?

Ms. HOVENIER. I believe the government can help other foster kids by—I don't know if it is already a thing or not, but implementing the foster child no matter what has a right to request a second opinion from a doctor or psychiatrist, no matter if it is a private paid therapist, private paid psychiatrist, and in addition, different forms of therapy besides just pharmaceutical therapy, like there is many therapies out there. I don't know them all, but those are just a couple of my ideas. Thank you.

Chairman REICHERT. Thank you. Good job.

Dr. Naylor, Illinois has the fifth largest foster care caseload in the country, with about 17,000 children in foster care. The program you administer oversees the prescription of psychotropic drugs to all of these children in foster care. How much does this program cost annually? Do you know what the cost is annually?

Dr. NAYLOR. I write the budget, and it is budget time, so I have a pretty good clue. It runs about $1.1 million, that is how much we have requested. We typically run it on about $900,000.

Chairman REICHERT. And how is your program funded?

Dr. NAYLOR. It is funded as a contract through the Department of Children and Family Services. The Children and Family Services receives funding from the State. In fact, their funding from the State is actually quite generous because of a consent decree from early 1990s, and some of the money comes from various Federal grants. I can't speak to how the money from DCFS comes to us, but it is either paid through general funds, which would be through the legislature or it comes from Children's Services funds, which are specifically earmarked to pay quicker. In Illinois, that is a very important factor I think, but pays quite a bit quicker than general funds.

Chairman REICHERT. What are some of the key outcomes that sort of tell you that your efforts have been successful, that they are making a difference?

Dr. NAYLOR. Well, I think there is several. One, in the written testimony, which I apologize, it didn't translate well from the Word document to the PDF, so there is some really weird things that happened when it was transferred to PDF, but you can see that there was over time a decrease in the use of Prozac or fluoxetine, and after the black box warning and after the warning regarding Paxil, we made the determination based on pretty sound evidence that fluoxetine should be the first drug of choice, and by changing our review process, we were able to do something that I don't think made the drug companies all that happy, which was we increased the rate of generic medication, fluoxetine, at the expense of brand name medications that were less effective. So one of the things that we were able to do was to increase evidence-based prescribing at a cost savings because the medication with the greatest evidence for it was also the medication that was the cheapest.

We were able also to show a decline in the use of antipsychotic polypharmacy, and these numbers actually are even more dramatic than you see in the written testimony because of the way we analyze this. We were very conservative.

Chairman REICHERT. You answered my last question to you. You just mentioned cost savings. Okay.

Dr. McGraw, you have spent your career focusing on mental health issues and how to appropriately address them. What do you believe is the best way to raise awareness of this issue so children are better protected from being prescribed these drugs that really aren't going to help them? What is the best way to get—one of these of course is today's hearing, with your presence that adds to it, but do you have some ideas on that?

Mr. MCGRAW. Well, I do. I think we need to keep just ringing the bell over and over because it is out of sight, out of mind, and I think so often these children become invisible, and their treat-

ment or their absence of treatment become invisible because they are just simply taken out of the mainstream, and I think that is why I said a hearing like we are having today is so important. We talk about this on the "Dr. Phil" platform, we talk about it on "The Doctors," kind of the medical version of our show, and people care about this, Chairman Reichert.

I know when we have had a call to action for CASA volunteers, it has just been overwhelming. I mean, we have been able to generate close to $90 million in volunteer services just from asking people to come forward and get involved. People want to get involved. They don't know how. And that is why something like a CASA is so important. For you and I, we had a football coach that kind of stepped up and jerked a knot in our tail and said, you know, get in class and be out here at practice, but, you know, you look at all of the psychological research, and I don't think there is anything more powerful for these children than a caring adult that puts their arm around their shoulder and says, I am going to help you navigate this maze.

So I think we just have to tell people about it, and we have got to tell them something they can do because if we get more adults involved in their lives, then these drugs are going to start to go away because there is going to be somebody there that says this is just a normal kid, a typical kid that has grown up in atypical circumstances. And we need to teach them, not medicate them, and I think that only happens when—you know, my dad used to say nothing makes the crops grow like the shadow of the owner, and it is the same way with your kids. Nothing protects your child than their biological parent, but if you don't have that, have a caring adult there that will pay attention to what is happening, and that is what happened to this courageous young woman here. We have got to have a call to action to get more people involved, and if you can't be a foster parent and bring children into your home, then you can be a CASA, which means you just navigate maybe two children a year through the process and watch over them, even if you can't open your home. If you don't have money to give, you can at least do that. So we have just got to tell people what they can do to become involved.

Chairman REICHERT. Thank you.

Mr. Doggett, you are recognized.

Mr. DOGGETT. Thank you very much, and thank you for your insightful and moving testimony. There is no doubt that everyone up here on this dais shares your concern. The question is whether or not we will take the action to do something to change anything, and that, whether that action will occur in a meaningful way is far from certain in this Congress.

Mr. Chairman, I would ask in that regard unanimous consent to enter into the record a letter from over 100 child advocacy organizations urging support for the administration's budget proposal to reduce the overmedication of foster children through a new demonstration project involving both child welfare and Medicaid agencies.

Chairman REICHERT. Without objection.

Mr. DOGGETT. And, Dr. Phil, I see that your foundation is among the organizations that signed that letter, and you have al-

ready talked about it. All of us are moved when we hear the stories from our CASA volunteers. I know I have been in Austin, in San Antonio. They do extraordinary work. But we can't solve this problem with just volunteers, without resources, as you have indicated. You said, and I think I got it down, it takes time, and it takes money, and it takes a completely different model.

If you would, just outline why you think it would be valuable to have these additional resources and attempt to have a demonstration project to help us combat the overprescribing of these medications to children in foster care.

Mr. MCGRAW. Well, Congressman Doggett, thank you for the question, and let me say, I think the worst thing we could do is throw more money at the model we have now.

Mr. DOGGETT. Right.

Mr. MCGRAW. If we throw more money to fund Medicaid or State agencies to keep writing these prescriptions and medicating these children, I think that would be disastrous. It would be like throwing gas on a fire. What it takes, and this is where money can be spent, is if you now have actual live people that will sit down and counsel these folks, give them the coping skills, the organizational skills, teach them how to talk to themselves about what has happened to them in their lives.

I spoke at a luncheon earlier today with these shadow foster kids here. What a great group, by the way, what an audience—you want to speak to those kids, let me tell you. But, you know, I said to them, sometimes you have to give yourself what you wish you could get from someone else. Maybe you don't have a parent there to put their arms around you and tell you how proud they are of you, but sometimes you have to give that to yourself. But they can't do that without having someone unravel this emotional ball of yarn for them. They have been abandoned. They have been neglected. They have been abused. Someone needs to tell them, what do you say to yourself about that? Psychology has made just wonderful advances with evidence-based therapies that give the kids the coping skills, the tools to do that. That is where the money should be spent, that is where the money will be spent with the new model, and that is why I support that, if it is done in that way, but it takes manpower. It takes manpower, and you are right, you can't do it with all volunteers, and sometimes the problems are over the volunteers' head. I mean, just over their skill set. If you have got someone that truly does have a mental illness that requires professional intervention, all the love in the world is not going to fix that. You need professional intervention to do that, and that is why you can't do it with all volunteer, and that is why the money would be well spent if it is not spent pouring more drugs on the problem.

Mr. DOGGETT. Ms. Chang, let me ask you to respond on that also with specifics because, clearly, we don't want to just pour more money into buying drugs. We would like to have some cost savings there. But why is it that additional resources are needed to get this other model going? Can you expand on what Dr. Phil has just told us?

Ms. CHANG. Sure, I would be happy to do that. I think when we think about a system that functions effectively, you need at a minimum three core components. You need the ability to screen

and assess so you can identify what is actually happening in that child's life and what their needs are. You need to then be able to connect what you have identified to appropriate evidence-based interventions, like Dr. Phil was talking about. And finally, you have to be able to monitor that child and follow them to make sure that that intervention is actually working for that individual child.

We do this in regular medicine all the time, right? If you go to your doctor, they are going to prescribe something for you. They tell you to come back and follow up, make sure that medicine worked. If it didn't, they will try something else. Far too often in child welfare, we are missing at a minimum those first two components, right? We don't have adequate screening and assessment tools that actually can identify what trauma that child has experienced and what that has done to that child's cognitive, social, emotional, mental health well-being, so we miss that first part. And even when we do have the capacity to measure what is going on in that child's life, what we have learned from the local jurisdictions is that they do not have access to the evidence-based interventions, and so there are many missing components. And that is why this demonstration is really designed to help local jurisdictions who want to do the right thing have the resources to either, to create for the first time or scale up evidence-based interventions. We know what works in the field, and often, as folks have said, it really is about family-based care, community-based care with mental health professionals who are trained in these evidence-based interventions.

Mr. MCGRAW. Congressman Doggett, I also want to add you are not really talking about new money here, by the way. Because what hasn't been talked about is these psychotropic drugs have addictive elements to them, and these children are at higher risk for addiction problems later in life if they have been on these drugs or abusing these actual drugs. And you are going to have to deal with that down the road if you don't deal with it here. If you take the drugs out and you put the right treatment and therapies in, you may spend that money doing it now, but you are not going to spend that money with lost productivity in society with someone that has an addiction problem later in life. So pay me now or pay me later, so you would do a whole lot better off to do it now and prevent the problems because one thing we know is when children get addicted to drugs, their development stops, their mental, emotional development stops, educational deficits set in.

Just because these were written with a prescription instead of on the street doesn't make their impact any different. The educational deficits, the developmental deficits, those things become profound, and you are going to pay for those later, and it is—that is why it is important to do it now, and whether you are—it is with reunification with the family or it is with these foster parents, most of which are absolute heros stepping up in these kids' lives, so, you know, you are not really talking about new money here. It is because just are going to spend it here or you are going to spend it there.

Mr. DOGGETT. Thank you very much.

Chairman REICHERT. Thank you.

Mr. Kelly, you are recognized.

Mr. KELLY. Thank you, Chairman.

Thank everybody for being here.

But if I'm listening to you, I may be hearing it incorrectly, Ms. Chang you maybe can help me on this. Seems to me that because we have had such a human breakdown in the family unit, that we have more of these children that are out there that cannot be taken care of by a mom and a dad and what we would consider a traditional family unit. So, overwhelmingly, I was reading the numbers, 400,000 children right now in foster care. That is as of 2012. I don't know where it is today. So is this—if you were to break it down demographically, are these from lower income or lower middle income people? Where are these children coming from?

Ms. CHANG. Sure. So, you are correct. We have a little less than 400,000 children in foster care today. I want to note that that is a huge mark of progress in the system. That is a reduction from over 500,000 children in care just about 10 years ago, so the system has made a difference. But you are right, these are young people who come from often low socioeconomic backgrounds. They come from challenging neighborhoods, and the abuse and neglect they experience before they came into care and then the trauma of coming into care even—even if they had to leave an abusive and neglectful family, coming into care can be traumatic, but most of these kids can be cared for in a foster home with a relative and most of them, in fact, are.

The great majority of our kids are placed with relatives or other foster families, and many of them don't have serious mental illnesses. Most of our kids have trauma symptoms that often are misdiagnosed as mental illness, and because we fail to intervene early on, they can escalate into much more serious behavior.

Mr. KELLY. I guess that is where my question comes in. So who does the intervention, who determines an intervention is necessary? And I think that is the part that bothers me. I have got eight grandchildren right now. And 9 and 10 are coming, and there is no two of them that are alike.

Ms. CHANG. That is right.

Mr. KELLY. Some are more challenging than others.

Ms. CHANG. That is right.

Mr. KELLY. The ones that are the most challenging, I wouldn't say his problem is he needs medication; I would say maybe he needs a little more parenting, but I worry about it.

Ms. Hovenier, you refer to now you actually have two families, two dads and a mom. I think that is interesting because you don't say I have two people taking care of them. You say the term that most of us have identified as growing up. I got a mom. I got a dad. I got people who care about me. I got people who love me. I got people who I can go to when I need to go to. I keep worrying about this and maybe you can weigh in on this. I know your father is with you now. Your dad is with you now, but I don't know about your early life. What happened that your—your little brother, was a 10-year-old, he was also in a foster home. Now, did you say you had a twin sister?

Ms. HOVENIER. I do, yes.

Mr. KELLY. Okay. Was your twin sister in a foster home?

Ms. HOVENIER. Yes.

Mr. KELLY. Okay. So, your whole family?

Ms. HOVENIER. Yes.

Mr. KELLY. Okay. All right. So that has got to be very difficult.

Dr. Phil, you deal with folks all the time. I have watched you a couple of times on TV. I don't have the chance to watch as maybe I would like to, but I see this breakdown of the family is what I see going on, and I think we are—we keep looking for government programs that somehow will do the job that families no longer do.

I grew up in an all together different time, and I will tell you when I talk to my friends, we agree on one thing: We grew up in the greatest towns at the greatest times with the greatest parents, preachers, teachers, coaches you could ever imagine, and a family support system. We didn't have as much of a support system government supplied. We had it family supplied, and that is the part that bothers me.

I look at a society that is going more to government for answers than it is to internally families making decisions, families deciding what to do to help a child, families being involved in the final determination of who goes on what or what they get prescribed to them. You see it in great numbers. You all see it in great numbers, but I keep coming—if our families continue to break down the way they are breaking down, there is not enough money in the world out there to take care of these children that are just out there going around aimlessly.

Mr. MCGRAW. Well, that is why it is so important to focus on reunification. And by the way, I would be happy to get you a DVR so you could watch more often.

Mr. KELLY. No, no, no, that is okay. Thank you. I appreciate that

Mr. MCGRAW. No, that is—the whole reason—and when I say the foster system is broken, the goal has to be reunification. We have got to restore the American family unit in America. I mean, we have become a much more transient society. We used to go down and play on the corner and didn't go home, but now we go to target schools and different places around. It is a different time, but we have got to reinstitute the family unit in America, and that is breaking down, and I see it more and more every day where parents drop their child off at school and expect them to be raised. That can't happen. It has got to start at home.

As parents, we—the same sex parent is the most powerful role model in any child's life, and that is where it begins, and you cannot advocate that role to anyone, and that is why reunification has got to be such a goal in this foster system.

Mr. KELLY. I agree with you, but it is a socialization process we are missing out on today. I got to tell you, the way I grew up, there wasn't anybody substituting for my mother and my dad.

And, Ms. Hovenier, I congratulate you in getting through what you have gotten through, but I think there is too many children out there who do not have the benefit of having a strong nuclear family. And I think that is the number one problem. If you don't have a strong nuclear family, you don't have a strong faith-based folks, you are not going to be able to get through it on your own. You just can't learn it by yourself through a book or through a program. Thank you.

Chairman REICHERT. Mr. Griffin, you are recognized.

Mr. GRIFFIN. Thank you, Mr. Chairman.

Thank you all for being here. I am from Arkansas, and we have had quite a bit of success in Arkansas dealing with this particular problem, and you know, there is a lot of—a lot of jokes and a lot of things said about Congress, but I will tell you that a lot of the progress we have made has been because of the laws that we have been able to get in place. And you know, I was just looking, reminded of 2011, which was my first year of serving here, we had the Child and Family Services Improvement Innovation Act, which deals specifically with the protocol for prescribing psychotropic medication for children. When I look at some of the results of what has gone on in Arkansas, it has been incredible, and it, no doubt, has been encouraged and in some cases mandated by the Federal Government, but the boots on the ground, as we say in the Army, has been at the State level.

And some of the numbers here—well, let me just say, a number of—a number of specific edits or, as they are called, or changes were put in place. One of them in particular was having a child psychiatrist review all requests for psychotropic medications for children under 5 and a whole host of things, but the numbers are staggering. There was a reduction for foster care children under 6 years old, a reduction of 86 percent. That is almost elimination. For nonfoster care, 92 percent, so there is a gap—there is a gap between the nonfoster care children and the foster care children. When you get to 6 to 12 years, reduction of 38 percent for foster care; 49 for nonfoster. So there is something that works here, it seems to me, and I think—I think the point that, Dr. Phil, you made and some others and some folks up here made is a good one, and that is, look, we have seen that throwing money at a problem doesn't work. The VA has been getting more money for administration after administration. I think we tripled the money for the VA in the last little over a decade, and it is still a disaster in many ways, and so we have got to make sure that we are funding the right things and that we are funding things on the ground, not more administrators, and I think that is critically important.

Now, the one thing I would—a couple of things to ask here. First of all, Dr. Naylor, in Arkansas, there is still a gap between—even though there have been significant reductions and great—very effective reforms, still a gap between foster care children and nonfoster care children. Dr. Phil mentioned earlier that there are certain problems or patterns with foster care children. He is—I think you said that there are more mental health problems as a percentage than in the general population. Maybe that explains the gap.

Dr. Naylor, could you—I see Dr. Phil shaking his head. Dr. Naylor, if you could speak to that, then Dr. McGraw, Dr. Phil, whichever one you want to go by, if—apparently, you chosen Dr. Phil. But if you all could both speak to that, what is the gap? Why is there a gap? So, when we see a reduction, the reduction is not as much with the foster care population as it is with the nonfoster care.

Dr. NAYLOR. Well, and I have how many minutes to answer that?

Mr. GRIFFIN. I will give you as much as you want. He may not.

Dr. NAYLOR. Excellent. All right. I think that there is several reasons. I summarized some of them in my testimony. I really think that these youngsters, you cannot, first of all, pathologize kids in foster care or foster children because the vast majority of them are able to carry out their roles that they are supposed to be carrying out, being part of a foster family, being part of a home of a relative, going to school and things like that, but there is a subgroup, and I think that this is a larger group in foster kids than in the general population.

I was asked by Bryan Samuels, who came from Illinois, actually, and he asked me if I really believed that there was a higher rate of mental illness in foster kids, and my answer to him, was if you really wanted to come up with a model for developing mental illness in a population, that is the perfect model. You have kids who—a sub-population anyway, are born to very impulsive, very aggressive, sometimes mentally ill, very often substance abusing and even sociopathic parents, strike one. Strike two, in these families, very often there is neglect. Neglect is probably worse in some ways even than physical abuse is. Physical and sexual abuse. There is often in utero exposure to drugs, which you know, between tobacco and alcohol, you have got to two biggest risk factors for screwing up the kid's brain. And we continue on through disruption of the primary attachment.

And you look at these kids and you think, how can you possibly love a mom who treats you like this or a dad who treats you like this? But they do, you know, and that is what they know. And I think the major trauma in the child welfare system actually is when you take the kids and how you take the kids into custody.

In—you know, people talk about the trauma of taking kids out of the home, but let me paint a picture for you. You are going to school. All of a sudden the police come to you at the school. They pick you up, chuck you in the back seat of the car, and bring you off to some strange place. Now, if you look at this from an evolutionary point of view, abduction equals death. And so when you are responding to this as a child, you are not responding to just, oh, what a bummer, you were taken away from your family. You are responding to a potentially life-threatening situation. I mean, that is what your brain is telling you.

And I think that we end up then seeing incredible sadness and maybe even more than that, a howling rage for some of these kids at being taken out of their families. And then the first foster home sometimes stick, but for a lot of these kids, there is multiple placement disruptions. And every single disruption that you have is accompanied by a decreasing sense of self worth and an increase in behavioral problems. And so we have the perfect system for developing emotional, behavioral, and psychiatric victims.

Mr. GRIFFIN. Mr. Chairman, I would ask that——

Chairman REICHERT. I think this is—I think this is an important question. The time has gone 2, almost 3 minutes over.

Dr. Naylor, you did an outstanding job. I happen to have been one of those police officers years ago that was put in those positions, and I will allow Dr. Phil McGraw to respond in a sound bite, please.

Mr. GRIFFIN. Thank you, Mr. Chairman.

Mr. MCGRAW. I will be as quick as I can. I don't disagree with anything Dr. Naylor just said, but I might approach him from a different standpoint. Being a foster child is a social circumstance. It is not a mental illness. It is a social circumstance. You do not treat a social circumstance with a drug. You have to fix the underlying problem, and you have got to do a differential diagnosis. You have got to say, is the etiology here organic? I mean, is there a biochemical imbalance that needs to be corrected inside the body, or has someone gone through some type of psychological trauma that has threatened their safety and their security and their self worth and their ability to predict the consequences of their life and their action. And if that is the case, I just don't believe that you are going to fix that with medication long term.

Now, it doesn't mean it can't help short term because it certainly can, but particularly for these young children, there is not one shred of evidence that many of these drugs are appropriate to use with 1- and 2-year-old children, certainly in a polypharmacy circumstance. And I am not down on psychotropics because, let me tell you, they can save and change lives when appropriately used, but being a foster child is a social circumstance, not a mental illness.

Now, it can trigger depression and some other things that have to be dealt with, but what is the treatment of choice? Is the treatment of choice to begin drug therapy? Is the treatment of choice to begin some type of evidence-based psychological therapy? And I think the former has many more side effects than the latter and therefore is much more dangerous.

Chairman REICHERT. Thank you. Thank you for your answer.

Mr. Renacci, you are recognized

Mr. RENACCI. Thank you, Mr. Chairman.

I want to thank the panel. You know, one thing great about being in Congress—I have only been here 3 and a half years—is you do get to learn a lot. I was in the business world for 30 years, and I have always believed in a safety net. There is no doubt about that. Coming from Ohio, there are 12,000 Ohio children living in foster care each month. You know, when the State agrees to take on the responsibility of caring for those children and the safety of the vulnerable population, it becomes their responsibility, and too many times we set them up for failure, not success, which I keep hearing as I am listening to this panel. And as I started to read about some of the headlines, you know, regarding this issue, "Out of Sight, Out of Mind: Psychotropics and Foster Care," "Mind-Altering Psych Drugs for 7-Year Old," these are just media stories that are—as you start to read and figure out what is going on, and you know, when the odds are already really against these individuals, that is very concerning.

So what I am trying to do is get some answers, and I listened. One thing I did hear you say, Dr. McGraw, is throwing additional money onto this problem is not the answer—the current system, I should say. Now, redirecting it might be the answer, but before I let you respond to that, I do want to ask Dr. McGraw and Dr. Naylor, in each of your opinions, really, where is the push for the use of psychotropic drugs coming from? You know, is it the child welfare system? Is it the medicaid system? Drug companies? Foster

parents? Schools? Or somewhere else? I would like to get either of your opinions on that.

Dr. NAYLOR. Well, I think that the routes into a psychiatrist's office varies. So, very often, as a child psychiatrist, I will hear variations of this story. Johnny, who is in foster care, has just lost his third preschool, and his fourth preschool is going to kick him out. He is running around the house, chasing the cat with a knife, and you need to do something and you need to do something now. And very often, these kids will have had therapy.

The problem is, is that not all therapies are correct. So one of the routes in is because the psychotherapy that is provided is not particularly effective and not evidence-based, but something needs to be done now. And this can come from foster parents. This can come indirectly from schools through the foster parents into the office. Very often, it is caseworkers who don't necessarily know how to negotiate a mental health system. And you would think that mental health systems and child welfare systems work together. You would also be very wrong if you thought that. I mean, they are very much silos. And so I think very often, child welfare workers then will say, okay, I know this psychiatrist that treated one of my other. I will bring this youngster in.

I don't—I think that also as a child psychiatrist sitting in the office, I look at what is available to make an intervention right now that might be able to head off a psychotropic medication. And one of the biggest problems is access to evidence-based therapies. Like I say, I can get somebody to play Chutes and Ladders with them and talk about nondescript things, but I can't get good evidence-based therapy.

Mr. RENACCI. So the push is from all of the above?

Dr. NAYLOR. Yeah.

Mr. RENACCI. Dr. McGraw?

Mr. MCGRAW. Well, you can tell you are talking to somebody that knows and lives this system, because when he says, I can get somebody to play Chutes and Ladders with them, but if you have got somebody that truly has a serious self-destructive problem, it takes a much higher level of professionalism.

Here is the problem: Your caseworkers might have 40 files, and in those—a given file might have 8 kids in it, so you are just talking about being completely overwhelmed, and so what you are doing is you are warehousing the problem short term. You say, I have got somebody chasing the cat with the knife and the school won't let him back in, so you want to take him? What are you going to do?

And so what they do—that is why I use the term chemical straightjacket. That is exactly what they do. They put the kid in a chemical straightjacket till they can figure something out, but the figuring out part never happens. The figuring out part never happens.

Mr. RENACCI. Can you elaborate on your comment earlier about throwing more money at this, and just give us here a better solution or what your solution would be?

Mr. MCGRAW. What I am saying is right now, we are overusing psychotropic drugs. That is the model. We are overusing them. And if you throw more money at it, what you are going to do is you are

going to spread that problem. That is not the fix. What you have got to do is change the model and then finance the model.

You cannot just pour money on the existing model. You have got to change the model, and then say, okay, that is all well and good there, Dr. Phil, but how are you going to—how are you going to give that caseworker access to the professional level of intervention that they need? Where are you going to get the therapist? How are you going to do that? Where you going do it? And that takes manpower, and manpower takes money, and that is what I am saying. You have got to change the model to one that is intervention based instead of medication based. And that takes manpower, and manpower takes money.

Chairman REICHERT. Time has expired.

Mr. Boustany, you are recognized.

Mr. BOUSTANY. Thank you, Mr. Chairman.

And thank you for holding this hearing. It is a really important hearing.

My wife is a CASA in south Louisiana. I have been hearing about all the horror stories and problems that are sort of built into the system, as all of you have very, very concisely described today, and we were having a conversation not long ago over the kitchen table, and she said, you guys have to do something about this. It is a huge problem. And then when she heard through CASA channels that we were having this hearing, she said, thank God that we are doing this, that we need to look at this problem. And so I want to thank you. I want to thank the panelists for being here.

I am also a medical doctor and have real concerns on a number of issues. One, Dr. Phil, you mentioned the fragmented nature of all this, and my wife has really schooled me on this whole system and how fragmented decisionmaking is and everything else. And you couple that with the psychotropic drugs of which, and you correctly said earlier, nobody really knows the mechanism of how they really work but they do save a lot of lives, but it is even more of a pronounced situation in children, adolescents, in understanding what the long-term impacts will be, especially if the drugs are used inappropriately. I mean, the adolescent in childhood, the neurological systems function a whole lot different and they respond differently to these drugs.

But I want to drill down on something. And that is, where is the decision made oftentimes or for the most part? Is there a pattern? Where are the decisions made to put these children on these drugs? I mean, obviously, they see a social worker, a CASA will see them. They may be in the court system. They don't go straight to a psychiatrist, and the psychiatrist or the family doctor or general practitioner is the one who has prescribing authority, but somebody is making a decision, sending it—then sending him through a psychiatrist or general practitioner, the family practitioner who then writes a prescription, and I am not convinced in the system that we have today that the person prescribing the medicine is actually following these cases and applying best practices, you know, and appropriate follow up. So I just would like one more comment on how this decisionmaking is made at that level to get these kids on these drugs.

Ms. CHANG. So I can begin, and certainly other folks can weigh in. I think the question is a good one, and I think that is why screening and assessment is so critical. When we don't have appropriate screening and assessment tools, we are shooting in the dark, right, and so people are not making informed decisions, no matter who it is that instigates that process, so we need to make sure that that is happening.

We are really pleased actually that Louisiana is one of our grantees who is focused on installing universal trauma-based screening and assessment in the State for all children in the child welfare system. And they are actually one of our State grantees who came to us and said, We do want to do this grant, we want to be successful, we have installed screening and assessment tools so that we can identify what kids actually need. And many of them don't need psychotropic medications.

The problem they found was they didn't have access to the evidence-based interventions the kids do need, and that is the real challenge. And as Dr. Phil says, you know, it costs money to scale up evidence-based interventions. You have to train physicians. You have to train social workers. You have to monitor the program itself to make sure it is being implemented with fidelity. You have to have data systems that can track the outcomes of these kids. That costs money. And so, you are right, from the very beginning, we don't have systems in place to actually identify what it is these kids need, so many people are shooting in the dark.

And also another challenge is that we have to be realistic. A lot of our kids do not have access to providers in a timely way that they need them, right. Some of our kids are waiting for 6 months to see a physician, and so you can imagine that the caseworker knows that that child is not going to see that doctor again perhaps for another 6 months, and so they are doing what the best that they can with the tools that they have available to them, and what we want to do is to expand their toolbox so that they have the right instruments they need to serve individual children where they are.

Mr. BOUSTANY. Is there an appropriate review process in many of the States? You know, after a child is put on psychotropic medication, obviously, you need to, you know, track it and monitor it and review the appropriateness of the therapy. I mean——

Ms. CHANG. Well, thanks to Congress, led by this committee and through passage of legislation in 2011, we now have a Federal mandate that all child welfare system have a process in place to oversee the psychotropic medication use of children in their care. And what we have heard from researchers, although it is still really early because now it has only been a few years that these processes have been in place, what researchers are finding and they are very excited is that it has made a difference.

So your actions have made an impact in the lives of children, and what we want to do is take it to that next step

Mr. BOUSTANY. Thank you.

Chairman REICHERT. The gentleman's time has expired.

We will move on to Mr. Crowley.

Mr. CROWLEY. Thank you, Mr. Chairman.

Thank you for holding this hearing today. And to Mr. Doggett as well, the ranking member.

Dr. Phil, I am desperate to try to ask you a profound question and hope I might get on your television show, but I can't come up with one, but I do want to thank you for the attention you are bringing to this issue.

You mentioned the shadow—the foster youth in the shadows today, and I think the real attempt here is to bring them out of the shadow and into the light that all of society can better understand the circumstances that they are living in, so thank you for that.

I have the opportunity—and I also want to thank my good friend and colleague Karen Bass, who is not a member of the subcommittee, but I am hopeful, will have an opportunity to say a few words as well. She, since coming to Congress, has been an incredible leader on the issue of foster care. I dabbled a little bit into it, and she has really taken over and really ran with it, so I really appreciate all she has done for this effort. But I had the opportunity this morning to meet with a very impressive young lady named Chanise, who was following me this morning, and we had opportunity to share some of her experiences and exchanged some ideas and thoughts and to try to find some solutions and actions that can take place to effectively bring about the changes that are needed within the foster care system.

And that is what our charge here in Congress is to do is to try to find ways to bring about change of things that need fixing. And certainly I think the foster care system is in need of our attention. We have seen the data on how common it is for children in foster care to be prescribed these psychotropic medications, in some cases, multiple medications at one time, and in fact, Chanise shared with me her own experiences in terms of medicated—being medicated at a very, very young age.

And medication is the medication is trying to solve an issue that perhaps could be better addressed through intervention as has been discussed here earlier today. That is something that, as I mentioned, I talked to Chanise about, but it is also something in my home State of New York, where I think new ground is being broken. And I appreciate the work that is taking place there. We need to separate out what is a problem generally worthy of medicated treatment and what is better served by a social worker or other personal engagement. While reducing medication can be a worthy goal in and of itself, we want to make sure we are also focusing on a comprehensive approach that includes alternative treatments.

New York has been a leader in trying to address the problems of overmedicated—overmedicating foster youth. New York is one of five States, including Illinois, as I believe, Dr. Naylor, you may be familiar with, participating in a 3-year initiative developed by the Center for Health Care Strategies and made possible through the Annie E. Casey Foundation. This initiative focuses on in collaborative—collaboration among State agencies to develop more effective practices for the use of these medications in foster care. State experts in New York tell me that this initiative has highlighted important areas that need to be addressed in order to have successful policies on this issue.

For example, one of the first challenges they had to meet was how to share data amongst the various agencies because while the Office of Children and Family Services was responsible for overseeing the foster care system, the actual medical treatment data was under Medicaid within the Department of Health, and the Office of Mental Health was also involved as well, so even just to survey how widespread the problem is required a new level of interagency cooperation. New York was fortunate that they honed in on this issue early and were able to address it. I know other States may be struggling with similar data-sharing problems, so I urge them to look at New York as an example.

Beyond just the data-sharing aspect, it is critical that multiple agencies work productively together. You have situations where the foster care agency may make recommendations or set protocols, but the doctors prescribing the medication are under the Department of Health. Everyone needs to work together in order to get the best results possible.

One of the lessons New York has learned is to emphatically stress collaboration and to ensure that each part of the system understands the impact that reaches beyond a single agency.

Ms. Chang, I see that the ACF has sought to encourage this collaboration through their demonstration, so I was wondering if you could possibly expound upon that and comment on what is taking place.

Ms. CHANG. Sure. Thank you. We agree with you. We think that collaboration is critical. Children in the foster care system are not served by one agency. They are served by multiple agencies. The Medicaid agencies, the mental health agencies, as well as child welfare, and so that is why we are really excited that this proposal has both an ACF component as well as a CMS component, and that goes to part of what I said about having access to providers.

We know that we have to create incentives so that there are physicians who are willing to care for our kids, that we have to create incentives to say that the Medicaid offices can also get funding to pay for the types of supports that they need so that there are providers, and it brings those two groups—major groups that serve these people—these children to the table to work together.

Mr. CROWLEY. Thank you.

Thank you, Mr. Chairman. I yield back.

Chairman REICHERT. Thank you, Mr. Crowley.

Mr. McDermott, you are recognized.

Mr. MCDERMOTT. Thank you, Mr. Chairman. I—full disclosure, I was trained at the University of Illinois and worked at Allendale School, so I know a little bit about the Illinois system.

My question is really, let's take Dawna. She goes into foster care and somebody writes a script for her to have medication. And I am talking about today, not 3 or 4 years ago when this happened, but today in Illinois. How would that be evaluated before she got the medication? Or would it be a retrospective evaluation 6 months later? Or when did it happen and by whom and did they ever see her? How would that decision have been made for her?

Dr. NAYLOR. That is a good question, and I—there are various ways of doing these reviews prospective and retrospective being the two major categories. Ours is a prospective one, so we review all

of the requests before the medication is actually prescribed and dispensed.

Mr. MCDERMOTT. So she is creating havoc in the house as a rebellious teenager, which she says she was. Somebody says this kid needs to be on drugs, so somebody writes a script, and then how long does it take to get to you and your independent agency to make a decision about whether she should have them or not?

Dr. NAYLOR. I hate to use you as an example, but you are hospitalized right now, and so the medication request comes to DCFS and our program at the very same time, and it has all of the diagnostic information, all of the symptom information, all medications that she would be on, and our review is not a true second opinion. We don't have the resources to be able to send somebody out to do an evaluation, and I think we have like 2,700 kids on medication. That would take a lot of resources to have a second opinion on everybody.

And so the work becomes, there is a diagnosis and the symptoms match, if they match, is the treatment something that would be recommended or recognized treatment for that combination of diagnoses and symptoms. If it is, is the dose requested being—an appropriate dosage, and if that is the case, we would approve the medication.

Mr. MCDERMOTT. How often do you reject a request for medication for a patient? A thousand scripts come in to you, you look at a thousand of them, how many times do you say no?

Dr. NAYLOR. That is a complicated question, and I will go through it as quickly as I can. I don't deny all that many requests anymore. And the reason I don't deny all that many requests anymore is because I have been doing this now for 15 years, and initially, when I started the program, people would talk to my boss and complain about Dr. Naylor's idiosyncratic psychopharmacology, and so they would rant and rave against what my recommendations would be. But my boss knew that I was arguing science and arguing good clinical care, and so, over time, people have changed their prescribing practices, and so that is one thing we do.

Another thing that we do is we ask really embarrassing questions like, do you really think it is a good idea to start this patient, who is psychotic, on a stimulant, which can cause psychosis? And the very act of asking the question will—again, because I have been there for 15 years, will lead to the doctor withdrawing the request for the medication because they know that if they persist, it will be denied.

So we deny probably 1 percent. There is probably 8 percent that are rescinded, but this is down from about 15 percent denials and fairly high rescinding rate about 10 years ago.

Mr. MCDERMOTT. And then 6 months later or a year later, you have now put her on the medication, you think it is a good idea, what is the possibility it will ever be looked at again by someone?

Dr. NAYLOR. Well, in terms of the consent process, by law, I will look at that again in 6 months. We only provide consent for every 6 months. And we will ask for a clinical update. If, at any point along the way, including with the first time that they made a request for the medication, I can request a second opinion from another physician, or if it is one of those cases that would end up

on the front page of the newspaper, I will sometimes go out and do these second opinions, so we will follow up with getting as much clinical information as we can get in order to make a determination whether that medication is still indicated or not.

Mr. MCDERMOTT. If she ran into a CASA worker who said—and she said, I don't think I should be on this medication, can I get off it, can you help me get off it, and they called you—can they call you? Can they appeal to you? Is there any way of appeal to you to review what is going on there?

Dr. NAYLOR. Absolutely. We actually have several different ways in where requests for a rereview can be made, and these requests can come from guardian ad litems, CASA workers, judges, juvenile judges, caseworkers. The nurses in Illinois are like another pair of eyes and ears, and they will often refer back for additional consultation. And now psychologists are also out in the field doing similar kind of monitoring work, so we will get consultation requests that way.

A foster child can go to the guardian ad litem and say I would like a second opinion on my medication, and we will find a way to get a second opinion done, so yes, there is.

Mr. MCDERMOTT. Ms. Chang, is this common across the United States? The Illinois system is something as comprehensive as that?

Ms. CHANG. This particular model of reauthorization is not as common.

Mr. MCDERMOTT. Not as common. Give me numbers here.

Ms. CHANG. So I can't give you a 50-State survey. I am happy to get back to you, sir, and tell you exactly how all States are structuring it. Most States, based on our review, do have a monitoring after the fact, and really, the—many of those programs are highly successful. Texas is a good example of that. They have protocols for when medication can be used, and they have a systematic way of reviewing all scripts to make sure that they follow the protocol. They also then look at individual physicians who break protocol more than once, and so they have a very effective way of managing medication, even though it doesn't involve preauthorization. And we find that most States employ that type of protocol and then making sure that doctors are following it.

There are other models. For example, Massachusetts makes sure that there are mental health professionals who specialize in medication management who are always available to social workers, caseworkers, as well as other physicians who are seeing these kids so that whenever questions come up, they can immediately get professional assistance because oftentimes, one of the problems is that these are folks without the expertise in prescribing these types of medications, so there are a variety.

Mr. MCDERMOTT. Thank you.

Thanks for extending my time.

Chairman REICHERT. You are welcome.

Thank you, Mr. McDermott.

And Ms. Chang, if you can provide that information in writing to the committee, I think that was a very good question, we would like to have that additional information, if you please.

So, I am just going to repeat a few things that I heard today, and then you can leave. We will wrap this up. First of all, I heard—I think we are all on agreement—we just don't want to pour money into a system that currently is not operating at 110 percent, right? So, we recognize there is some work there to do. Ms. Chang is working with the States in trying to bring States along to develop systems, and Illinois is a great example of some great progress that has been made, but we all can do better.

I think, in listening to Ms. Hovenier and her suggestions, you know, I really like the idea of no matter what, a second opinion. I think coming from you, that has a lot of power behind it.

Choices of therapy, I think Dr. McGraw and Dr. Naylor and others have mentioned that sometimes some therapies just don't work because it is the wrong therapy. So that was a great point that you made.

And then the mention of tools, the proper tools for screening, for assessment and evidence-based, I think is really, really critical, and that is when you begin to apply the resources and the funding when you know that you have got evidence-based information to make decisions on. I think all of the panel would agree with that, and I think the members that were here today would agree with that.

And I want to thank, again, all of you for taking time out of your busy schedules to be here today. This is such an important topic, and all the members here that were here to ask questions and listen to your testimony.

And again, a special thank you to Ms. Bass for her work in this arena and helping us schedule this hearing.

So if members have additional questions, those of us who are left, for the witnesses, they will submit them to you in writing, and we would appreciate receiving your responses for the record within 2 weeks. The committee now stands adjourned.

[Whereupon, at 4:13 p.m., the subcommittee was adjourned.]

[Questions for the record follow:]

Congress of the United States
House of Representatives
COMMITTEE ON WAYS AND MEANS
WASHINGTON, DC 20515

SUBCOMMITTEE ON HUMAN RESOURCES

June 5, 2014

JooYeun Chang
Associate Commissioner of the Children's Bureau
Administration for Children and Families
Department of Health and Human Services
1250 Maryland Ave., SW,
Washington, DC 20024

Dear Associate Commissioner Chang:

Thank you for testifying at our May 29, 2014 hearing and for sharing your expertise related to the use of psychotropic medications among children in foster care. Because of time limitations, there was one point you made during the hearing that we were unable to fully explore. I would like to ask you to provide the Subcommittee with additional information on this issue, and I have included my question below that I hope you will answer in writing by June 19, 2014. As I mentioned at the end of the hearing, we will include your answers in the official hearing record.

Thank you again for your participation in our hearing, and I look forward to receiving your response.

Sincerely,

D. Reichert

Dave Reichert
Chairman

Questions for the Record
Hearing on "Caring for Our Kids:
Are We Overmedicating Children in Foster Care?"

On May 29, 2014, the Ways and Means Human Resources Subcommittee held a hearing titled "Caring for Our Kids: Are We Overmedicating Children in Foster Care?" Testimony submitted by Associate Commissioner JooYeun Chang noted that the Child and Family Services Improvement and Innovation Act of 2011 "requires states to report to HHS protocols they have in place for monitoring the use of psychotropic medications."

First, have all states developed protocols to monitor the use of psychotropic medications for children in foster care, and reported those protocols to HHS as required in the law?

Second, can you provide us with the protocols each state has submitted regarding how they plan to monitor the use of these drugs?

Third, can you characterize the various approaches states have taken to address this issue? For example, some states like Illinois review all prescriptions for psychotropic medications before they are given to youth in foster care. Do we know how many states follow this practice? Other states review their Medicaid payment data to find questionable prescription practices. Do we know how many states review their Medicaid data in this way? What other practices, if any, are common among states?

Finally, what data is available from states on how the implementation of these protocols has affected (1) the number of foster youth who are prescribed any psychotropic medication, (2) the number who are prescribed multiple medications, and (3) other key data about psychotropic medication use by youth in foster care?

[Submissions for the record follow:]

Letter of the Adopt America Network

May 27, 2014

The Honorable John A. Boehner
Speaker
United States House of Representative
1011 Longworth House Office Building
Washington, D.C. 20515

The Honorable Eric Cantor
Majority Leader
United States House of Representative
303 Cannon House Office Building
Washington, D.C. 20515

The Honorable Nancy Pelosi
Minority Leader
United States House of Representative
235 Cannon House Office Building
Washington, D.C. 20515

Dear Speaker Boehner, Majority Leader Cantor and Minority Leader Pelosi:

As representatives of organizations committed to improving the health and wellbeing of our nation's children and families, we are writing to urge your support for a new and important initiative outlined in the Administration's 2015 budget. This five-year collaborative demonstration, involving the Administration for Children and Families (ACF) and Centers for Medicare and Medicaid Services (CMS), is designed to encourage states and tribes to provide evidence-based psychosocial interventions to children and youth in foster care and to reduce the inappropriate use and over-prescription of psychotropic medications for this population.

We appreciate the recent attention that Congress has brought to this important issue in the form of oversight hearings and request for governmental reviews of state practice. We believe that the proposed demonstration builds on recent Congressional efforts, and if implemented, will lead to improved outcomes for vulnerable children with behavioral health challenges and children exposed to trauma – often resulting from child abuse and neglect.

The joint proposal put forth by ACF and CMS will help coordinate efforts to build state and tribal capacity within child welfare and health care systems to more appropriately address the high rates of children who may be unnecessarily receiving psychotropic medications, often several at one time, even as few receive appropriate outpatient mental health services. The project will encourage the utilization of effective evidence-based therapeutic interventions, including therapeutic foster care, intensive in-home and community-based approaches, Multisystemic Therapy, and mobile response and stabilization services.

State prescribing practices received considerable attention in 2011 with the release of a Government Accountability Office (GAO) report[1], which reviewed medication utilization under the Medicaid program. The report found that 20-39 percent of children in state foster care received prescriptions for psychotropic medication in 2008, compared with only 5-10 percent of children on Medicaid not in foster care. More alarming, the report also found that children in state foster care are prescribed dosages at far higher rates than their peers served by Medicaid, and often in amounts that exceed guidelines issued by the Federal Food and Drug Administration (FDA). GAO's

[1] U.S. Government Accountability Office. (2011, December) *Foster Children: HHS Guidance Could Help States Improve Oversight of Psychotropic Prescriptions*. (Publication No. GAO-12-270T). Retrieved from GAO Reports Main Page via GPO Access database: http://www.gao.gov/assets/590/586570.pdf

findings are supported by a large number of recent studies. As a follow up to GAO's report, in 2011, the Senate Homeland Security and Governmental Affairs Committee also held a hearing on this issue.

Available data speaks to the need for immediate Congressional action to implement strategies aimed at improving the psychosocial wellbeing of our most vulnerable children. To that end, the 2015 budget proposal specifically requests a five-year joint project through ACF and CMS to promote more effective evidence-based interventions targeting children in foster care beginning in 2015. Under ACF, the budget includes an investment proposed at $50 million a year to fund state infrastructure and capacity building to ensure improved coordination between CMS and child welfare agencies.

We also encourage the inclusion of tribal governments in this collaborative demonstration to address issues related to American Indian and Alaska Native children who are affected by the inappropriate or over use of psychotropic medication. American Indian and Alaska Native children can be in either state or tribal foster care systems with medications being provided by agencies that are sometimes in different jurisdictions. Improving coordination between these jurisdictions is critical to effectively addressing medication issues with this population. This funding could be used to better train stakeholders (including foster parents and adoptive parents, judges, etc.), provide reliable screening and assessment tools, implement evaluation procedures and improve data collection. These efforts will better help children in foster care who sometimes fall through the cracks of a fragmented health planning process.

Simultaneously, the CMS investment is proposed at $100 million a year to provide incentives to states that demonstrate improvements in these areas. The overall goals of this important and timely initiative are to reduce inappropriate prescribing practices and over utilization of psychotropic medications, increase access to evidence-based and trauma-informed therapeutic interventions, promote child and adolescent wellbeing, and improve child welfare outcomes (as related to safety, increased permanency, fewer disrupted adoptions and reduced entries and re-entries into foster care).

Although small in terms of budget requests, this demonstration project will build on existing priorities and recent reforms led by Congress, and will help to not only curb inappropriate use of psychotropics, but also to incentivize the use of a variety of evidence-based psychosocial interventions that have been found to be effective. We believe it will also make critical improvements needed in the child welfare system and help to better address the effects of trauma on children in foster care, those placed in adoptive families and all young victims of child abuse and neglect.

Moving forward, we can better serve children and youth and help keep them safe in families by developing a more coordinated and comprehensive approach to addressing the behavioral health care needs of children served by Medicaid, many who are victims of child abuse, are in foster care or exposed to various forms of trauma including sexual exploitation and trafficking. The following organizations strongly urge you to take action to ensure this important project is funded so that better policies, improved transparency, and improved health outcomes are achieved for our nation's children and families.

Sincerely,

Adopt America Network

Adoption Exchange Association

Adoption Network Cleveland

Adoption Rhode Island

Advocates for Children and Youth (Maryland)

Advocates for Children of New Jersey

All Saints Church Foster Care Project (California)

Alliance for Children & Families

American Academy of Pediatrics

American Association on Health and Disability

American Orthopsychiatric Association

American Psychological Association

Arkansas Advocates Children and Families

Association for Community Affiliated Plans

Attachment & Trauma Network, Inc.

Brighter Beginnings (California)

California Alliance of Child and Family Services

California Association of Adoption Agencies

California Church IMPACT

Center for Adoption Support and Education

Center for the Study of Social Policy

Child Welfare League of America

Children and Family Futures

Children Awaiting Parents

Children Now (California)

Children's Action Alliance (Arizona)

Children's Alliance (Washington)

Children's Defense Fund

Children's Dental Health Project

Children's Home Society of North Carolina

Clinical Social Work Association

Colorado Coalition of Adoptive Families

Community Action Partnership

Congressional Coalition on Adoption Institute

Consortium for Children (California)

County Welfare Directors Association of California

Dave Thomas Foundation for Adoption

Depression and Bipolar Support Alliance

Donaldson Adoption Institute

Dr. Phil Foundation

Every Child Matters Education Fund

FACES of Virginia Families

Family Builders Network (California)

Family Design Resources, Inc.

Family Equality Council

Family Voices New Jersey

First Focus Campaign for Children

Florida's Children First

Foster Care to Success

Foster Family-based Treatment Association

FosterClub

Generations United

Healthy Schools Network (New York)

Hillcrest Children and Family Center (Washington D.C.)

Holt International Children's Services

Hudson Family Partners

John Burton Foundation (California)

Joint Council on International Children's Services

Kentucky Youth Advocates

Kidsave

Kinship Center, A Member of Seneca Family of Agencies (California)

Koinonia Family Services (California)

Lilliput Children's Services (California)

Lutheran Services in America

Marguerite Kondracke (Former CEO of America's Promise)

Mental Health America

Mental Health America- Los Angeles

MOMS Advocating Sustainability (California)

National Adoption Center

National Alliance on Mental Illness (NAMI)

National Association for Children of Alcoholics (NACoA)

National Association of County Behavioral Health & Developmental Disability Directors

National Association of County Human Services Administrators

National Association of Social Workers

National Association of State Mental Health Program Directors

National CASA Association

National Child Abuse Coalition

National Children's Alliance

National Council of Juvenile and Family Court Judges

National Federation of Families for Children's Mental Health

National Foster Care Coalition

National Foster Parent Association

National Indian Child Welfare Association

National Leadership Council on African American Behavioral Health

National League for Nursing

National Respite Coalition

Nebraska Appleseed

Nebraska Families Collaborative

New Jersey Alliance of Family Support Organization

New York Council on Adoptable Children

North Carolina Association of County Directors of Social Services

North American Council on Adoptable Children (NACAC)

NYS Office of Children and Family Services (New York)

Oregon Post Adoption Resource Center

Parents Anonymous

Partners for Our Children (Washington)

Pennsylvania Partnerships for Children

PolicyLab at The Children's Hospital of Philadelphia

Prevent Child Abuse Arizona

Public Policy Center of Mississippi

Spaulding for Children (Michigan)

Statewide Parent Advocacy Network (New Jersey)

Texans Care for Children

The Adoption Exchange (Colorado)

The Committee for Hispanic Children and Families, Inc. (New York)

The Kempe Center

The National Crittenton Foundation

The Ray E. Helfer Society

The Villages of Indiana

Three Rivers Adoption Council (Pennsylvania)

Voice for Adoption

Voices for Children in Nebraska

Voices for Utah Children

Voices for Virginia's Children

Wisconsin Council on Children and Families

Youth Law Center

Youth Villages

Statement of James Harris

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Hearing Title: "Caring for Our Kids: Are We Overmedicating Children in Foster Care?"
Hearing Date: May 29, 2014

Responsive to a letter from Chairman Camp to Congressman Marchant, I am delighted to submit these comments regarding prescription drug diversion as it relates to overmedication of children. Fortunately, one of the witnesses for the Hearing, Dr. Phil McGraw, already broached the subject of diversion and sale of medications as a driver of overuse. Although Dr. Phil only described the sale of medication to the street by patients, it is common knowledge that profit seeking drives caregivers to encourage/participate in the exaggeration of symptoms for profit. As one example of schemes plaguing the 24th District of Texas, local parents seek to have all children in their care prescribed with the highest doses of ADHD medications possible so that the medications can be diverted for abuse or sold to others. According to DEA statistics assembled from the Federal Register, the current national Compounded Annual Growth Rate of prescribed stimulants (used to treat ADHD) is 33.4% and has grown nearly 1900% since 1994 (see chart). The black market drives enormous needless medical spending [1] and simultaneously causes social disruption, all because symptoms are readily feigned and no accountability systems exist.

I am seeking Members who are looking for voter-resonant facts upon which to attack the administration. For example, while I am a knowledgeable person, I still do not understand why the Benghazi issue should warrant my long-term attention. I don't think this puzzlement is unique among voters. Conversely, I believe the public would be engaged by an investigation/hearing/etc showing that federal agencies purposely avoid taking action to attempt to prevent prescription drug experimentation by youth and reduce the supply to the black market. Only 16% of the public say that we are making progress on addressing the prescription drug crisis – the most pessimistic measure among all public health challenges studied by Pew Research [2].

As a case in point, Vatex can show that NIH are actively covering up a research agenda that promotes the interests of middling pharmaceutical companies. The pro-pharma agenda is supported by funding projects that increase the supply of Controlled Substances for diversion and simultaneously stopping projects that seek to decrease diversion. These are serious accusations, but Vatex has the evidence to back them up. By way of background, I am ex-FDA and ex-pharma, so I understand the industry playbook.

Regarding the NIH example above, it is not currently possible to determine whether they have been duped or paid to take these actions – either way, they and other agencies are prolonging the crisis. For all these reasons, I urge Members to reach out for evidence because this problem has all the ingredients needed to capture the public's attention: agency incompetence or malfeasance, mortality, family disruption, criminality, workforce degradation, military readiness, healthcare fraud and inflation, and strong growth ahead.

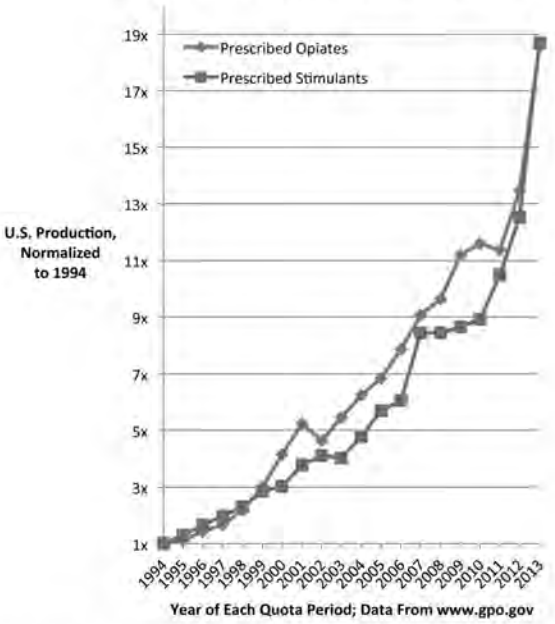
References:

1. "Today, prescription drug abuse is the fastest-growing drug problem in the county – and contributes to nearly 40,000 deaths and **almost $200 billion in health-care costs annually**." [emphasis added]
http://www.justice.gov/usao/flm/press/2011/oct/20111028_Pill%20Nation%202_AG_Remarks.pdf

2. http://www.pewresearch.org/fact-tank/2013/11/13/americans-see-u-s-losing-ground-against-mental-illness-prescription-drug-abuse/

[continues on next page]

The Approval of Oxycontin in 1996 Coincided With the Early Industrialization of a National Black Market



Method used to build the chart - For each final DEA quota report printed in the Federal Register:

Prescribed Opiates: add fentanyl + hydrocodone + hydromorphone + methadone + oxycodone (sale) + oxymorphone (sale)

Prescribed Stimulants: add amphetamine (sale) + lisdexamfetamine + methamphetamine + methylphenidate

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