The Children Are Crying: The Need for Change in Florida's Management of Psychotropic Medication to Foster Children

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Abstract

Foster children often have serious emotional and behavioral problems due to the trauma they experience before entering foster care. Behavioral problems regularly disrupt foster placements and make maintaining permanency in foster placements difficult. Trying to maintain permanency in foster placements creates a pressure to medicate. When medication takes preference over individual or family therapy, foster children can become overmedicated. In Florida overmedication continues to be a problem where the number of foster children receiving a psychotropic medication was at one point, three times the national average.

The administration of psychotropic medication to foster children is an area of growing national concern. Articles often discuss the overmedication of foster children, but do not consider what administrative changes can be made to reduce this phenomenon. Against this backdrop I set out to compare Florida's current medication consent process with the approaches of two other states in order make recommendations Florida could implement for improvement.

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This article provides general information about psychotropic medication and discusses how consent is obtained.

In Florida foster children may not be administered a psychotropic medication without express and informed consent from a parent, or the court. Florida statutes, administrative codes and agency guidelines work together to create the medication consent process. However, Florida's actual oversight of the process fell short, leaving some foster children without legally required consent on file. Two states, Tennessee and Texas, are highlighted in the article for the unique changes made to their medication consent processes. By implementing successful tools from other states, Florida can correct pitfalls in its process and improve the mental health treatment foster children receive.

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Introduction

> *"[Three weeks before his death on April 16th, 2009], Gabriel Myers [a child in Florida's foster system] was prescribed Symbyax, a combination of generic forms of the anti-depressant Prozac and the antipsychosis drug Zyprexa. Although it is unclear if Gabriel was administered his prescription, the burden of the pain he suffered was left untreated, Gabriel hung himself with a shower hose at the age of 7."*[1]

Like Gabriel, children in Florida's foster system continue to receive psychotropic medication to conceal the side effects of their painful pasts. Children in foster care have high rates of serious emotional and behavioral problems;[2] likely due to the circumstances surrounding their entry into the foster care system. These children often suffer from physical disabilities, birth defects, developmental delays and poor

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[1] *Report of Gabriel Myers Work Group*, GABRIEL MYERS WORK GROUP (2009), *available at* http://www.dcf.state.fl.us/initiatives/GMWorkgroup/docs/GabrielMyersWorkGroupReport082009Final.pdf.

[2] *Foster Children and the Health Care System: Hearing Before the Subcomm. on Income Security and Family Support of the H. Comm. on Ways & Means*, 110th Cong. 1-3 (2007), *available at* http://www.aap.org/fostercare/PDFs/07-19-07%20W&M%20Foster%20Care%20Testimony%20Rubin.pdf [hereinafter Rubin testimony] (testimony of David Rubin on behalf of the Am. Acad. of Pediatrics); Am. Acad. of Child & Adolescent Psychiatry, *Practice Parameters for the Psychiatric Assessment of Children and Adolescents*, 36 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 10S, 5S (1997); *Psychiatric Care of Children in the Foster Care System*, AM. ACAD. OF CHILD & ADOLESCENT PSYCHIATRY (2001), http://www.aacap.org/cs/root/policy_statements/psychiatric_care_of_children_in_the_foster_care_system; Mental Health Subcomm., Steering Comm. on Families & Children in the Ct., *Transforming Florida's Mental Health System: Constructing a Comprehensive and Competent Criminal Justice/Mental Health/Substance Abuse Treatment System: Strategies for Planning, Leadership, Financing, and Service Development*, 84 (2007), *available at* www.floridasupremecourt.org/pub_info/documents/11-14-2007_Mental_Health_Report.pdf.

school achievement.[3] The combination of multiple disorders and inadequately monitored treatments put additional burdens on an already exhausted dependency system.[4] Foster children routinely "fail in school, attempt or contemplate suicide and begin involvement with juvenile justice."[5] While various therapies exist to help children cope with serious emotional and behavioral problems, children in foster care often receive prescriptions for psychotropic medication.[6] Studies indicate children in foster care receive an excessive amount of psychotropic medication as compared to their non-foster care peers.[7]

In Florida, children in out-of-home care[8] are three times more likely to be treated with psychotropic medication

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[3] Rubin testimony, *supra* note 2.

[4] National Center for Children in Poverty, *Children's Mental Health: Facts for Policymakers* (Nov. 2006), *available at* http://www.nccp.org/publications/pdf/text_687.pdf.

[5] National Alliance on Mental Illness, *Schools and Families United for the Mental Health and Well-Being of Children*, 1 (Nov. 2007), *available at* http://www.nami.org/Template.cfm?Section=schools_and_education&template=/ContentManagement/ContentDisplay.cfm&ContentID=57186.

[6] Julie M. Zito et al., *Psychotropic Medication Patterns Among Youth in Foster Care*, 121 PEDIATRICS 157 (Jan. 2008), *available at* http://www.pediatrics.org/cgi/content/full/121/1/e157; RICK MAYES ET AL., MEDICATING CHILDREN; ADHD AND PEDIATRIC MENTAL HEALTH, 136 (2009).

[7] *Prescription Psychotropic Drug Use Among Children in Foster Care: Hearing Before the Subcomm. on Income Security & Family Support of the H. Comm. on Ways & Means*, 110th Cong. 4-7 (2008) [hereinafter Zito testimony], (testimony of Julie M. Zito, Professor of Pharmacy and Psychiatry, Pharmaceutical Health Services Research, University of Maryland) (stating two thirds of children in foster care receive psychotropic medication, far exceeding children not in foster care.); (statement of Chairman McDermott) (Nationally, foster children are three to four times more likely to be prescribed psychotropic medication than other children receiving Medicaid Services) *available at* http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110_house_hearings&docid=f:45553.pdf.

[8] Used as synonym for foster care, in the context of this paper out-of-home care refers to the placement of a child, arranged and supervised by the Department of Children and Families or its agent, outside the home of the child's custodial parent or legal guardian. FLA. ADMIN. CODE ANN. r. 65C-35.001(16) (2010).

than the national average.[9] This number is evidence of either a staggering number of children suffering from emotional and mental illness or a lackadaisical approach to prescribing psychotropic medication to children. One Florida review revealed that 424 psychotropic medications were prescribed to a mere 268 children, with 34% of children on two psychotropic medications and 11% on two or more.[10] The use of two or more prescriptions is known as polypharmacy.[11] Polypharmacy is an area of growing concern because little evidence exists that children benefit from taking multiple psychotropic medications.[12] Before removal from their homes, over 69% of the children reviewed did not take psychotropic medication.[13] These statistics indicate that in Florida, children removed from their homes without a prescription for a psychotropic medication will likely be given one upon entering out-of-home care.

Another Florida review found that 2,505 of the 18,982 children in out-of-home care received psychotropic medications.[14] Of the number of children given psychotropic

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[9] *Report of Gabriel Myers Work Group*, *supra* note 1, at 7 (nationally some 5% of all children are treated with psychotropic medications. In Florida's foster care system, 15.2% of its children receive at least one such medication, according to a report dated August 14, 2009); Tufts Univ., *Psychotropic Medication and Youth in Foster Care Report*, NEWSWISE, Sept. 23, 2010, *available at* http://www.newswise.com/articles/psychotropic-medication-and-youth-in-foster-care-report (psychotropic medication use in foster care ranges from 13-52% than those in the general population at 4%).

[10] Gabriel Myers Workgroup, *Meeting Minutes*, 1 (July 6, 2009), *available at* http://www.dcf.state.fl.us/initiatives/GMWorkgroup/docs/meeting070609/minutes.pdf.

[11] Polypharmacy is the prescribing of multiple psychotropic medications. *Prescribing Psychoactive Medication for Children and Adolescents*, AM. ACAD. OF CHILD & ADOLESCENT PSYCHIATRY (Sept. 20, 2001), http://www.aacap.org/cs/root/policy_statements/prescribing_psychoactive_medication_for_children_and_adolescents.

[12] *Id.*

[13] *Id.*

[14] Gabriel Myers Workgroup, *Psychotropic Medication Review* (Nov. 12, 2010), *available at*

medication, 25 children received medication without legal and documented consent from a parent or the court.[15] For over 60% of children in out-of-home care, consent was obtained through court order. Consent via court order places the decision to medicate on a judge, who has little personal interaction with the child if any.[16] The judge becomes an autocratic decision maker, ordering psychotropic medication to be administered solely because of paperwork offering a mere glimpse into the child's current life, feelings or concerns. While psychotropic medication can greatly help children in out-of-home care,[17] the medications have various side effects, such as suicidal behaviors, tremors, weight gain, and increased anxiety.[18] Therefore, judges are not the appropriate authority to order the administration of psychotropic medication because they lack the requisite knowledge to weigh the benefits against the risks associated with psychotropic medications.

The concern about the number of children receiving psychotropic medication is not new for Florida. In 2003, The Florida Statewide Advocacy Council issued a report about the increase in psychotropic medication prescribed to foster children.[19] Then in 2005, the Florida Legislature authorized the Medicaid Drug Therapy Management Program for Behavioral Health (hereinafter MDTMP), to refine the standards practitioners use when prescribing psychotropic medication.[20] The MDTMP developed best-practice

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http://www.dcf.state.fl.us/initiatives/GMWorkgroup/reports/MedsReport%202010-11-12.pdf.

[15] *Id*.

[16] Consent was court order for 1,536 children out of the 2,505 on psychotropic medication. *Id*.

[17] Am. Acad. of Child & Adolescent Psychiatry, *Practice Parameter on the Use of Psychotropic Medication in Children and Adolescents*, 48 J. AM. ACAD. CHILD ADOLESCENT PSYCHIATRY 962 (2009); Zito testimony, *supra* note 7.

[18] U.S. Food & Drug Admin., *Safety Review*, 2 (Feb. 28, 2006), *available at* http://www.fda.gov/ohrms/dockets/ac/06/briefing/2006-4210b_07_01_safetyreview.pdf.

[19] Gabriel Myers Workgroup, *Meeting Minutes*, *supra* note 10.

[20] *Medicaid Drug Therapy Management Program For Behavioral Health*, UNIV. OF S. FLA. COLL. OF BEHAVIORAL & CMTY. SCIENCES,

guidelines for the diagnosis and treatment of mental illness.[21] Finally, the 2009 suicide of seven-year-old Gabriel Myers, a dependent in Florida's foster care system, brought psychotropic medications to the forefront yet again. His death prompted the appointment of the Gabriel Myers Work Group to review Florida's guidelines and make recommendations addressing failures in Florida's system.[22] The review resulted in stricter enforcement of Florida's existing rules and guidelines, but greater protection of Florida's foster children was needed.[23]

In early 2010, Senator Ronda Storms responding to this need proposed a bill creating additional safeguards to protect children in out-of-home care.[24] Most notably, the bill required the appointment of guardian *ad litem* advocates to children proscribed psychotropic medication.[25] Guardian *ad litem* advocates oversee and report to the court concerning the health, physical care, and medical treatment of the child.[26] Although the bill never passed, it succeeded in raising awareness about the psychotropic medication process.[27] In April 2010, some of the Gabriel Myers Workgroup recommendations were adopted into the Florida Administrative Code.[28] The Gabriel Myers Workgroup uses

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http://flmedicaidbh.fmhi.usf.edu/program_overview.htm (last visited Oct. 30, 2010).

[21] *Id.*

[22] *Report of Gabriel Myers Work Group*, *supra* note 1, at i; FLA. DEP'T OF CHILDREN & FAMILIES, P*rioritizing Substance Abuse and Mental Health Treatment* (2009), *available at* http://www.dcf.state.fl.us/initiatives/fostercare/docs/SubstanceAbuseandMentalHealthFACTSHEET111909.pdf.

[23] Interview with former Dep't of Children & Families Case Manager (Oct. 28, 2010) (on file with author)(hereinafter Interview).

[24] Carol Marbin Miller, *Regulations Sought for Foster Kids Prescribed Psychiatric Drugs*, MIAMI HERALD (Mar. 2, 2010), *available at* http://www.miamiherald.com/2010/03/02/1507445/regulations-sought-for-foster.html.

[25] I*d.*; S.B. 0724, 2010 Leg. (Fla. 2010).

[26] FLA. STAT. § 39.829 (2010).

[27] *Id.*

[28] Gabriel Myers Work Group, *Status Report*, 7 (2010), *available at* http://www.dcf.state.fl.us/initiatives/childsafety/docs/GMStatus.pdf.

information from the Florida Safe Families Network (FSFN) to monitor adherence to the current rules and guidelines.[29] FSFN is a statewide-automated system that keeps electronic records of a child and his or her family.[30] Case managers are responsible for entering the child placement and medication information into the FSFN.[31] When case managers properly update the FSFN, the network will contain the name of the child's proscribed psychotropic medication, the dosage, the name of the prescribing practitioner, and whether consent has been granted.[32]

A 2009 review of 2,952 cases in the FSFN found 5,551 deficiencies that needed correction.[33] The deficiencies included a lack of documented informed consent, an absence of court orders to administer psychotropic medication, and various data entry errors.[34] Specifically, for 8% of children receiving medication, the FSFN did not list a prescribing party,[35] and an unsettling number of cases lacked documentation of legally informed consent.[36] Without regular monitoring of the FSFN and the physical case file, data entry errors can lead to a child being unlawfully medicated.

While it is easy to blame typographical errors and missing paperwork for the over medication of foster children, the issue Florida must address is larger than simple clerical errors. To properly address Florida's failures and make

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[29] *Report of Gabriel Myers Work Group*, *supra* note 1, at 20.
[30] FLA. ADMIN. CODE ANN. r. 65C-35.001(11) (2010).
[31] FLA. ADMIN. CODE ANN. r. 65C-35.007(5) (2010).
[32] FLA. ADMIN. CODE ANN. r. 65C-30.011(4).
[33] *Report of Gabriel Myers Work Group*, *supra* note 1, at 20.
[34] *Id*.
[35] Gabriel Myers Work Group, *Special Quality Assurance Review: Children Ages Six and Seven in Out-of-Home Care on Psychotropic Medications: Findings* (July 6, 2009), *available at* http://www.dcf.state.fl.us/initiatives/GMWorkgroup/docs/meeting070609/July6presentationDaniels.pdf (June Review of 268 cases of children age 6 to 7, in 32 of which a prescribing practitioner could not be identified).
[36] Gabriel Myers Work Group, *Special Quality Assurance Review: Children Ages Ten and Eleven in Out-of-Home Care on Psychotropic Medications: Preliminary Findings*, 5 (Aug. 5, 2009), *available at* http://www.dcf.state.fl.us/initiatives/GMWorkgroup/docs/SpecialQualityAssuranceReview080509.pdf.

recommendations, a complete understanding of Florida's psychotropic medication process is required. The focus of this paper is not to criticize the care of children under the protection of the Department of Children and Families (hereinafter DCF), nor to blame those who work in the trenches of the dependency system. This paper will focus on problems in the medication consent process and make recommendations to improve the supervision of children who receive psychotropic medications in out-of-home care.[37] To increase oversight, Florida should utilize medical advocates, medication review, consent by mental health practitioners, electronic medication logs and medical record, and use the child's pediatrician to supervise the child's care. These changes will increase the quality of information exchanged and the case manager's ability to oversee the medication consent process. To properly review the administration procedures and guidelines, it is imperative to understand the dangers and risks associated with the use of psychotropic medications in children. Therefore, part I will briefly review the most commonly prescribed psychotropic medications in Florida's foster system. It will summarize how psychotropic medications work and identify potentially harmful side effects. Part II will discuss the difficulty of diagnosing mental illness. Specifically, it will address the importance of parental involvement, what happens when the state fills the parental role, and the effect of environmental factors on the diagnosis.

Part III will describe how Florida's current statutory and administrative laws control the dispensation of psychotropic medication to children in out-of-home care. In particular, it will note potential pitfalls in the effectiveness of the guidelines, to protect Florida's children from potential medication mistakes, misdiagnosis or unnecessary polypharmacy. Part IV highlights where Florida is succeeding in the monitoring of psychotropic medication administration. It will also address successful processes used by other states

[37] In this paper, out-of-home care means the placement of a child outside the home of the child's custodial parent or legal guardian, arranged and supervised by the Department of Children and Families or its agent. FLA. ADMIN. CODE ANN. r. 65C-35.001(16) (2010).

and recommend that Florida implement some of these procedures into its own system.

I. Psychotropic Medication Generally

> *"Data on safety and efficacy of most psychotropics in children and adolescents remain rather limited and are in sharp contrast with the advances and sophistication of the adult field. In child and adolescent psychiatry, changes in clinical practice have, by far, outpaced the emergence of research data and clinical decisions are frequently not guided by a scientific knowledge base."*[38]

For the purpose of this paper, the term psychotropic medication encompasses "any chemical substance prescribed with the intent to treat psychiatric disorders or other medical illnesses, with the effect of altering brain chemistry."[39] These medications include but are not limited to stimulants, and anti-psychotics or selective serotonin reuptake inhibitors (hereinafter SSRIs).[40] Stimulants increase the release of dopamine and norepinephrine, chemicals in the brain that control mood, pain, and pleasure.[41] Stimulants then block the reuptake of dopamine and norepinephrine in the brain.[42] This reuptake creates a "feel good" effect, similar to cocaine, which

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[38] State of Tenn. Dep't of Children's Services, M*edication Monitoring Guidelines*, 1 (May 1999), *available at* http://www.dcf.state.fl.us/initiatives/GMWorkgroup/docs/meeting061809/Medication%20Monitoring%20Guidelines%20Final%20Draft%20.pdf (quoting B. Vitiello et al., 38 J. AM. ACAD. OF CHILD & ADOLESCENT PSYCHIATRY 501 (1999)).

[39] FLA. ADMIN. CODE ANN. r. 65C-35.001(18) (2010).

[40] *Id*.

[41] U.S. Dep't of Justice, *Methylphenidate*, DRUG ENFORCEMENT ADMIN. (Feb. 2011), http://www.deadiversion.usdoj.gov/drugs_concern/methylphenidate.pdf; *Dopamine*, PSYCHOLOGY TODAY, http://www.psychologytoday.com/basics/dopamine (last accessed March 16, 2011).

[42] *Id*.

increases the potential for stimulant abuse and addiction.[43] Adderall, the most prescribed stimulant to Florida's foster children,[44] surpassed Ritalin,[45] as the most widely used medication for the treatment of Attention Deficit Hyperactivity Disorder (hereinafter ADHD).[46] Adderall, like its predecessor Ritalin,[47] is a schedule II controlled substance.[48] Schedule II substances are categorized by the Drug Enforcement Administration as those having an accepted medical purpose but whose abuse may lead to severe physical and psychological dependence.[49] Although Adderall is clinically proven to treat ADHD, as a schedule II controlled substance, it has a high potential for abuse and addiction.[50]

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[43] *Id*.

[44] E-mail from Jason Gaitanis, Dep't of Children & Families, Data Reporting Admin., Family Safety Program Office (Oct. 26, 2010, 3:30PM) (on file with author).

[45] Lawrence H. Diller, *The Run on Ritalin: Attention Deficit Disorder and Stimulant Treatment in the 1990s*, 26 THE HASTINGS CTR. REPORT 12-18 (1996).

[46] Lawrence H Diller, *The Ritalin Wars Continue*, 173 W. J. OF MED. 366-367 (2000), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1071175/#ref1 (citing IMS, National Prescription Audit, January through December 1999); Statistics on Stimulant Use, PBS FRONTLINE, http://www.pbs.org/wgbh/pages/frontline/shows/medicating/drugs/stats.html (last accessed Nov. 15, 2010). Two behavioral dimensions are thought to underlie the core symptoms of ADHD, inattention and impulsivity, however the diagnostic criteria includes 18 specific symptoms.

[47] Lawrence Diller, *The What, When, and How of Taking Ritalin*, PBS FRONTLINE. http://www.pbs.org/wgbh/pages/frontline/shows/medicating/drugs/diller.html (last visited Oct. 30, 2010).

[48] U.S. Dep't of Justice, *Information & Legal Resources*, DRUG ENFORCEMENT ADMIN., http://www.deadiversion.usdoj.gov/pubs/manuals/pract/section2.htm (last accessed Nov. 15, 2010).

[49] Office of Diversion Control, *Practitioner's Manual*, U.S. DEP'T OF JUSTICE DRUG ENFORCEMENT ADMIN., (2005), *available at* http://www.justice.gov/dea/pubs/abuse/doa-p.pdf.

[50] 21 U.S.C. § 812(b)(2)(A)-(C) (2010).

In Florida, Zoloft and Prozac, are prescribed frequently to treat foster children suffering from depression.[51] Both Zoloft and Prozac are FDA approved SSRI's for use in children,[52] and work by increasing levels of serotonin in the brain, essentially improving the child's mood.[53] The most prescribed anti-psychotic medication to Florida's foster children is Abilify.[54] Abilify is labeled for the treatment of psychotic disorders such as Schizophrenia and Bipolar Disorder.[55] The symptoms associated with these disorders include poor emotional response, delusions and hallucinations which debilitate a child's daily functioning.[56] Uncertainty exists as to how Abilify works,[57] and as a result, little is known about the effect of Abilify on long-term development.

A. Side Effects Associated with Psychotropic Medication

Psychotropic medication, while helpful in treating a variety of mental illnesses, can have uncomfortable and harmful side effects. Stimulants can increase blood pressure, heart rate, body temperature, decrease sleep and appetite,[58] as

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[51] E-mail from Jason Gaitanis, *supra* note 44; U.S. Food & Drug Admin., *Questions and Answers on Antidepressant Use in Children, Adolescents, and Adults: May, 2007*, U.S. DEP'T OF HEALTH & HUMAN SERV., www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/ucm096321.htm (last updated Sept. 3, 2010).

[52] U.S. Food and Drug Admin., *supra* note 51.

[53] U.S. Food and Drug Admin., *Pediatric Clinical Trials for Anti-Depressant Drug Products*, U.S. DEP'T OF HEALTH & HUMAN SERV. (2004) [hereinafter Woodcock statement], *available at* http://www.fda.gov/NewsEvents/Testimony/ucm113266.htm (statement of Janet Woodcock, M.D.); *Selective Serotonin Reuptake Inhibitors* (SSRIs), MAYO CLINIC (Dec. 10, 2008), http://www.mayoclinic.com/health/ssris/MH00066.

[54] E-mail from Jason Gaitanis, *supra* note 44.

[55] ABILIFY (ARIPIPRAZOLE), http://www.abilify.com (last visited Nov. 15, 2010).

[56] *Psychosis*, AM. ACAD. OF CHILD & ADOLESCENT PSYCHIATRY, http://www.aacap.org/cs/root/resources_for_families/glossary_of_symptoms_and_illnesses/psychosis.

[57] *Id*.

[58] National Institute On Drug Abuse, *NIDA InfoFacts: Stimulant ADHD Medications: Methylphenidate and Amphetamines*, 2 (June 2009), http://www.drugabuse.gov/pdf/infofacts/ADHD09.pdf.

well as exacerbate tics.[59] In high doses, stimulants have been connected to serious cardiovascular complications, including stroke.[60] Sudden death is the most serious side effect of stimulants; usually occurring in patients with unrecognized cardiovascular abnormalities.[61]

SSRIs and anti-psychotics have both been linked to a presence of suicidal thoughts and attempts.[62] Less disturbing side effects linked to SSRIs include: a loss of social inhibition, emotionality, activation, irritability, and agitation.[63] Side effects of anti-psychotics include tics, increased heart rate and blood pressure, vomiting, increased appetite and weight, sleepiness, and affect the body's ability to regulate temperature.[64] While parents have concerns about the numerous side effects the medications produce, parental concern increases when the phrase "off label" is used.

B. Concerns about Off Label Use of Psychotropic Medication

"Off label" refers to the use of a medication for a purpose other than the one specified on the label.[65] Often medication that is proven effective for adults is used in children displaying the same symptoms or diagnosis.[66] Off-label use in this context means the medication is not labeled for use in children.[67] This means the medication has not

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[59] Thomas D. Challman & James J. Lipsky, *Methylphenidate: Its Pharmacology and Uses*, 75 MAYO CLINIC PROCEEDINGS 711-721 (2000).
[60] National Institute On Drug Abuse, *supra* note 58.
[61] U.S. Food & Drug Admin., *supra* note 18, at 2.
[62] Thomas D. Challman, *supra* note 59 (noting sucidality is twice that of children on placebos).
[63] U.S. Food & Drug Admin., *supra* note 18, at 2.
[64] ABILIFY (ARIPIPRAZOLE), *supra* note 55; Tammy Worth, *Healthy Weight or Healthy Mind? Psych Drugs Can Pile on Pounds*, CNN (Nov. 9, 2010), http://www.cnn.com/2010/HEALTH/11/09/health.psych.drugs.weight.gain/.
[65] *Treatment of Children with Mental Disorders*, PSYCHCENTRAL (Sept. 2000), available at http://psychcentral.com/disorders/childtreatment.htm.
[66] *Drug Research & Children*, U.S. FOOD & DRUG ADMIN., www.fda.gov/Drugs/ResourcesForYou/Consumers/ucm143565.htm (last updated May 1, 2009).
[67] *Id.*

undergone scrupulous scientific testing in children.[68] Off-label drug use represents 50-75% of pediatric medication prescriptions.[69] It is entirely permissible to prescribe psychotropic medication for purposes unstated on the label, even though off label use may not be safe or effective.[70] Ethical concerns surrounding the testing of psychotropic medication on children are to blame for the lack of scientific data on safety and efficacy.[71] For example, researchers have concerns about a child's ability to understand and consent to a scientific study.[72] Other experts in the field, question the responsibility of purposely refusing medication that helps children in order to obtain scientific data.[73] Failure to conduct medication trials has led to limited data supporting the effectiveness of non-stimulant psychotropic medication and its impact on a child's long-term development.[74]

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[68] *"Off-Label" and Investigational Use of Marketed Drugs, Biologics, and Medical Devices: Information Sheet*, U.S. FOOD & DRUG ADMIN., http://www.fda.gov/RegulatoryInformation/Guidances/ucm126486.htm (last updated May 22, 2009).

[69] Julie M. Zito et al., *Off-Label Psychopharmacologic Prescribing for Children: History Supports Close Clinical Monitoring*, 2 CHILD & ADOLESCENT PSYCHIATRY & MENTAL HEALTH 24 (2008), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2566553/ (citing R. Roberts et al., *Pediatric Drug Labeling*, 290 J. of the Am. Med. Assoc. 905-911 (2003)).

[70] *Id*.

[71] *Interview with Robert Temple, The Medicated Child*, PBS FRONTLINE (Jan. 8, 2008), http://www.pbs.org/wgbh/pages/frontline/medicatedchild/interviews/temple.html; *Promotion of Unapproved Drugs and Medical Devices*, U.S. FOOD & DRUG ADMIN., http://www.fda.gov/NewsEvents/Testimony/ucm115098.htm (last updated Aug. 6, 2009); *Drug Research and Children*, *supra* note 66.

[72] *Drug Research and Children*, *supra* note 66.

[73] *Interview with David Axelson, The Medicated Child*, PBS FRONTLINE (Jan. 8, 2008), http://www.pbs.org/wgbh/pages/frontline/medicatedchild/interviews/axelson.html.

[74] U.S. DEP'T OF HEALTH & HUMAN SERVICES, OFFICE OF THE SURGEON GEN., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL (1999), *available at* http://www.surgeongeneral.gov/library/mentalhealth/home.html (indicating

The Food and Drug Administration (hereinafter FDA) is responsible for approving new medications.[75] The approval process begins with the pharmaceutical company submitting an application, which includes the drug's trial results and labeling information.[76] If the FDA believes the benefits of the medication outweigh its known risks (established in the trial results) the drug will be approved and can be marketed in the United States.[77] The FDA took a two-pronged approach to remedy off-label use of medication in children and increase the number of pediatric clinical trials.[78] The first step was to grant pharmaceutical manufacturers six months of marketing exclusivity if they completed the required FDA drug trials.[79] This led manufacturers to conduct important pediatric clinical trials on the efficacy of their medication in children.[80] The second step was to warn parents of serious side effects by requiring Black Box warnings on all antidepressant medications.[81] A Black Box warning is the FDA's most serious warning and prevents pharmaceutical companies from sending reminder ads about the drug to practitioners. Prohibiting reminder ads decreases the likelihood a practitioner would prescribe a medication because he is not reminded of the drug's availability.[82] Unfortunately, the

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examples of non-stimulant psychotropics include SSRIs, mood stabilizers, antipsychotics).

[75] *What is the approval process for a new prescription drug?*, U.S. FOOD & DRUG ADMIN. (2010), http://www.fda.gov/AboutFDA/Transparency/Basics/ucm194949.htm.

[76] *Id*.

[77] *Id*.

[78] *Drug Research and Children*, *supra* note 66.

[79] *Id*.

[80] Woodcock statement, *supra* note 53; PFIZER, ZOLOFT (2008), http://media.pfizer.com/files/products/uspi_zoloft.pdf.

[81] *Id*.; Press Release, U.S. Food & Drug Admin., FDA Proposes New Warnings About Suicidal Thinking, Behavior In Young Adults Who Take Antidepressant Medication (May 2, 2007), *available at* http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/2007/ucm108905.htm.

[82] Press Release, U.S. Food & Drug Admin., FDA Launches a Multi-Pronged Strategy to Strengthen Safeguards for Children Treated With Antidepressant Medications (Oct. 15, 2004), *available at*

Black Box restrictions have not increased the number of psychotropic medication approvals submitted to the FDA, and some manufacturers have ignored the restrictions completely.[83]

II. The Difficulty of Treating Children in Out-of-Home Care

> *"It's really to some extent an experiment, trying medications in these children of this age. It's a gamble. And I tell parents there's no way to know what's going to work."*[84]

Foster children often receive limited healthcare. This is due to prolonged waits for community-based mental health services, lack of funding, and poor communication among health care professionals and the foster child's case manager.[85] A child's case manager is responsible for ensuring the safety and well-being of a child in out-of-home care.[86] In the context of psychotropic medication recommendation, this is accomplished by linking behavioral health service providers with foster parents, monitoring the delivery of behavioral health services and collecting information to determine the effect of such as treatment.[87] Case managers may assist parents or caregivers in locating medical services, coordinating psychiatric evaluations, and overseeing the completion of necessary paperwork.[88] A mental health

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http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/2004/ucm108363.htm.

[83] Press Release, Office of Criminal Investigations, U.S. Food & Drug Admin., Drug Maker Forest Pleads Guilty Will Pay More Than $313 Million to Resolve Criminal Charges and False Claims Act Allegations (Sept. 15, 2010), *available at* http://www.fda.gov/ICECI/CriminalInvestigations/ucm226396.htm

[84] Interview with Dr. Patrick Bacon, *The Medicated Child*, PBS FRONTLINE (Jan. 8, 2008), http://www.pbs.org/wgbh/pages/frontline/medicatedchild/view.

[85] *Id*.

[86] FLA. ADMIN. CODE ANN. r. 65C-35.001(9).

[87] FLA. ADMIN. CODE ANN. r. 65C-16.001(10).

[88] *Id*.; FLA. DEP'T OF CHILDREN AND FAMILIES, CF OPERATING PROCEDURE NO. 175-98: PRE-CONSENT REVIEW FOR PSYCHOTHERAPEUTIC

diagnosis relies heavily on reports of a child's behavior at home or school. For children in out-of-home care, Comprehensive Behavioral Health Assessment[89] recommendations, or complaints from foster parents and teachers, may result in a psychiatric appointment. Case managers are a vital source of information to practitioners who treat foster children with no parental involvement. Because behaviors are easily misinterpreted, practitioners and case managers must work diligently to determine the root cause of the behavior.[90]

A. What Frustrates Practitioners

Practitioners face a daunting task: diagnose a child based on a miniscule amount of information and identify other services the child may need.[91] Children often enter the foster system with a number of serious physical and mental illnesses.[92] The combination of illnesses, developmental delays, and fear make it difficult for a practitioner to provide care to foster children. A practitioner treating a child in the

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MEDICATION TREATMENT PLAN FOR CHILDREN FROM BIRTH THROUGH AGE 5 IN OUT OF HOME PLACEMENT (2009).

[89] FLA. DEP'T OF CHILDREN & FAMILIES, CF OPERATING PROCEDURE NO. 155-10: SERVICES FOR CHILDREN WITH MENTAL HEALTH AND ANY CO-OCCURRING SUBSTANCE ABUSE TREATMENT NEEDS IN OUT-OF-HOME CARE PLACEMENTS § 2-1 (2010), *available at* http://www.dcf.state.fl.us/admin/publications/policies/155-10.pdf; *Report of Gabriel Myers Work Group*, *supra* note 1 (The assessment must include direct observation of the child, by a licensed mental health practitioner, in three settings: home, school and community. Children in Medicaid may have one assessment each year.); *see also* DISABILITY WORKGROUP OF FLA. BAR FOUNDATION CHILDREN'S LEGAL SERVICES GRANTEES, COMPREHENSIVE BEHAVIORAL HEALTH ASSESSMENTS FOR CHILDREN IN STATE CARE, *available at* http://www.dcf.state.fl.us/initiatives/GMWorkgroup/docs/CBHAPacketFinal.pdf (last visited Dec. 5, 2010).

[90] DEP'T. OF CHILDREN & FAMILIES, A FAMILY GUIDE TO CHILDREN'S MENTAL HEALTH SERVICES AND SUPPORTS, 5.

[91] Comm. on Early Childhood, Adoption, and Dependent Care, *Health Care of Young Children in Foster Care*, Am. Acad. Of Pediatrics, 109 Pediatrics 536-541 (2002), *available at* http://aappolicy.aappublications.org/cgi/reprint/pediatrics; 109/3/536.pdf.

[92] Rubin testimony, *supra* note 2.

foster system must be ready to devote additional time to the child's care and be willing to work with little to no medical history or information.[93]

A mental health diagnosis cannot be conducted in a vacuum, as a child's functioning and psychological well-being are highly dependent on the family and school setting.[94] To obtain the most accurate diagnosis, it is vital the psychiatrist gather information from the child as well as family, teachers, caregivers, and parents.[95] Generally, a practitioner may need to interview the child more than once to accurately reveal the child's functioning level because he or she may resort to immature behavior when in unfamiliar situations.[96] It may be difficult to interview foster children on multiple occasions because foster children often rely on swamped case managers or transporters to get them to appointments.[97]

Because symptoms of mental illness can resemble other medical conditions, a practitioner's evaluation may include a physical exam, interviews, psycho-educational testing, and other medical tests such as an electroencephalogram to determine brain injury.[98] It is

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[93] Comm. on Early Childhood, Adoption, and Dependent Care, *supra* note 91.

[94] *Id*.; DEP'T. OF CHILDREN & FAMILIES, *Services For Children With Mental Health And Any Co-Occurring Substance Abuse Treatment Needs In Out-Of-Home Care Placements*, CF Operating Procedure 155-10/ CFOP 175-40, 2-5 (Sept. 13, 2010), *available at* http://www.dcf.state.fl.us/admin/publications/policies/155-10.pdf.

[95] AM. ACAD OF CHILD & ADOLESCENT PSYCHIATRY, *supra* note 2.

[96] *Id*.

[97] FLA. ADMIN. CODE ANN. r. 65C-35.004(2) (2010); DAVID E. WILKINS, FLA. DEP'T OF CHILDREN & FAMILIES, THE BARAHONA CASE FINDINGS AND RECOMMENDATIONS (2011), *available at* http://www.dcf.state.fl.us/newsroom/publicdocuments/Southern/Barahona/Barahona%20Case%20Findings%20and%20Recommendations%20-%20March%2014%202011/DCF%20Barahona%20Case%20Findings%20and%20Recommendations%20-%20March%2014%202011.pdf; Interview, *supra* 23.

[98] FLA. ADMIN. CODE ANN. r. 65C-35.002(5) (2010); AM. ACAD. OF CHILD & ADOLESCENT PSYCHIATRY, PSYCHIATRIC MEDICATION FOR CHILDREN & ADOLESCENTS PART I—HOW MEDICATIONS ARE USED, FACTS FOR FAMILIES (July 2008), *available at*

imperative that psychotropic medication be prescribed only when the child's behavior significantly impairs functioning in both home and school environments.[99] Currently, no diagnostic test exists to confirm a mental health diagnosis;[100] therefore, pediatric experts recommend that a child obtain an independent verification of a diagnosis to rule out other health issues or environmental causes.[101] While the Florida administrative code provides a process for requesting second opinions, the process is likely not used as often as it should be, considering the number of children prescribed psychotropic medications.[102]

B. When States Fill the Parental Role

> *"When at-risk children are taken into custody for their own safety, they become foster children, and we become their parents. Along with that comes a special obligation, I believe, to protect and care for them."*[103]

When parents refuse to consent, cannot be located or their rights are terminated, the state must take on the role of the prudent parent. When the state takes on this role, it often frustrates the psychiatric diagnosis because case managers and foster parents (who receive subsidies from the state) often do not understand the child's behavior as a parent would. Foster children can be more demanding on their home and school

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http://www.aacap.org/galleries/FactsForFamilies/21_psychiatric_medication_for_children_and_adolescents_part_one.pdf; *Epilepsy Health Center*, WEBMD, http://www.webmd.com/epilepsy/electroencephalogram-eeg-21508 (last updated July 29, 2008).

[99] *Conditions & Treatments*, MASS. GEN. HOSP., http://www.massgeneral.org/conditions/default.aspx?cat=197&catName=Psychiatry# (last visited Oct. 30, 2010).

[100] *Methylphenidate*, *supra* note 41.

[101] Kathleen Doheny, *ADD & ADHD Health Center: Immaturity Mistaken for ADHD?*, WEBMD (Aug. 19, 2010), http://www.webmd.com/add-adhd/news/20100820/is-it-really-adhd.

[102] FLA. ADMIN. CODE ANN. r. 65C-35.0012 (2010); *Report of Gabriel Myers Work Group*, *supra* note 1, at 7.

[103] McDermott statement, *supra* note 7.

environment, which frustrates foster parents and teachers.[104] Foster parents seek psychotropic medication as a way to lessen the disruption at school and home.[105] In Florida, ADHD is the most commonly diagnosed disorder in foster children, diagnosed nearly five times more often than the second leading disorder.[106] But it is impossible to ascertain whether foster children are predisposed to ADHD or if they are given medication in an attempt to control their behavior.

A practitioner needs a child's complete medical history to distinguish between normal childhood behaviors and signs of a mental illness.[107] Ideally, the child's parent would provide the child's medical history. However, when the state is the parent, the party accompanying the child should convey the pertinent information and Resource Record, which contains the available medical history of the child.[108] A child in out-of-home care may have a case manager, transporter, or foster parent shuttle them to and from medical appointments.[109] Unfortunately, this inconsistency prevents the child's Resource Record from getting into the practitioner's hands.[110] One study showed that in 75% of cases reviewed, practitioners did not receive pertinent

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[104] RICK MAYES, ET. AL., MEDICATING CHILDREN, ADHD AND PEDIATRIC MENTAL HEALTH, 59 (quoting GREENE and FORSTER, EFFECTS OF FUNDING INCENTIVES, 1-4).

[105] Diller, *supra* note 47.

[106] GABRIEL MYERS WORK GROUP, FLA. DEP'T OF CHILDREN & FAMILIES, SPECIAL QUALITY ASSURANCE REVIEW, 3, 6 (2009), *available at* http://www.dcf.state.fl.us/initiatives/GMWorkgroup/docs/meeting070609/July6presentationDaniels.pdf (of the 268 children ages 6-7 years, 85% have a diagnosis of attention deficit hyperactivity disorder).

[107] *Frontline: The Medicated Child* (PBS television broadcast 2008), *available at* http://www.pbs.org/wgbh/pages/frontline/medicatedchild/view/.

[108] Resource Record is the child's standardized record that contains copies of all available and accessible medical and psychological information, including behavioral health information, dental records, psychological and psychiatric history. FLA. ADMIN. CODE ANN. r. 65C-001(20).

[109] Gabriel Myers Workgroup, *Meeting Minutes*, 5 (June 8, 2009), *available at* http://www.dcf.state.fl.us/initiatives/GMWorkgroup/docs/meeting060809/minutes20090608.pdf; Interview, *supra* 23.

[110] Interview, *supra* note 23.

information.[111] This lack of information is incredibly frustrating for pediatricians and medical professionals. One pediatrician stated "[i]t's enough to make you want to throw up your hands, fill in the medical form, and give up."[112] Even with the best intentions, a practitioner is often hindered from making a complete diagnosis when the State is the parent.

Given the serious side effects many psychotropic medications carry, inherent parental concern often makes a parent more cautious about allowing a physician to prescribe such medications to their child. However, once a child is placed in out-of-home care and no longer under his or her parent's protection, it is up to the state to look after the child's physical and mental health. There is no guarantee that an adult responsible for a child in out-of -home care, will lie awake at night debating whether to place the child on psychotropic medication, like a parent would. The lack of cautiousness and innate parental concern are just a few reasons why the state is a poor substitute for a prudent parent.

The state's role as a parent is more than just creating guidelines and statutory laws to effectively administer medication to foster children. The state must become a prudent parent for children in out-of-home care; requesting second opinions, discussing the child's behavior, seeking information about a medication's side effects, questioning the need for psychotropic medication, and inquiring about potential alternatives.[113] The state fails as a parental substitute when it does not ensure these things are accomplished. It is this inadequate oversight that causes children with serious emotional and behavioral issues to receive too much or too little medication.

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[111] Marc Caputo, *System faulted in boy's death in foster care*, MIAMI HERALD, (July 7, 2009), *available at* http://www.dcf.state.fl.us/initiatives/GMWorkgroup/news/20090707-SystemFaulted.shtml.

[112] Barbara J. Howard, *Behavioral Consult Fostering Hope in the Foster Child*, 40 PEDIATRIC NEWS 30 No. 8 (2006), *available at* http://findarticles.com/p/articles/mi_hb4384/is_8_40/ai_n29308618/.

[113] *Report of Gabriel Myers Work Group*, *supra* note 1, at 2.

A. Factors Having an Impact on Treatment

Multiple factors play a role in deciding how to treat mental and behavioral health illnesses. Some of these factors include pressure from parents, teachers, and caregivers, Medicaid limitations, barriers to medical history, and aggressive pharmaceutical advertising. Treatment for mental illness broadly makes up three categories: psychotherapy, psychotropic medication and a combination of both.[114] Psychotherapy is a general term used to describe the addressing of mental health concerns by talking with a psychologist or mental health provider.[115] Advancements in psychiatric research have led to multiple therapeutic options for children and their families, some of the most common options are: Cognitive Behavior Therapy, Family Therapy, Play Therapy and Interpersonal Therapy.[116] Generally, therapy involves assisting the child and sometimes the child's family, learn new ways to express and deal with their feelings.[117] By helping children and their caregivers understand and resolve problems, therapy can effectively treat mental and emotional problems.[118] Psychotropic medications

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[114] U.S. Dep't of Health & Human Services, Office of the Surgeon General, *Mental Health: A Report of the Surgeon General*, 140, *available at* http://www.surgeongeneral.gov/library/mentalhealth/home.html; Interview with David Axelson, *supra* note 73.

[115] In psychotherapy you learn about your condition, moods, feelings and learn to respond to situations with healthy coping skills. Psychotherapy, MAYO CLINIC (Sept. 1, 2010), http://www.mayoclinic.com/health/psychotherapy/MY00186.

[116] AM. ACAD. OF CHILD & ADOLESCENT PSYCHIATRY, FACTS FOR FAMILIES: PSYCHOTHERAPIES FOR CHILDREN AND ADOLESCENTS, 1-2 (May 2008), *available at* http://www.wisaap.org/Resources/2010Resources/201010Resources/wccap%20psychotherapies_for_children_and_adolescents.pdf.

[117] Staff of the NYU Child Study Center, *Choosing a Mental Health Professional for Your Child: What, Where, Why and How* (July 2010), http://www.aboutourkids.org/families/seeking_professional_help/choosing_mental_health_professional.

[118] *Id.*at 2; U.S. Dep't of Health & Human Services, *supra* 114; National Alliance on Mental Illness, *supra* note 5.

affect chemicals in the brain related to mood and behavior.[119] There is no question that these medications are helpful to children. A combined treatment of medication and therapy can be especially effective. By using medication to calm the symptoms of the illness the child can learn new skills in therapy that provide long-term benefits. Unfortunately, therapy is often a secondary recommendation after prescribing a quick-fix medication to control mood and problematic behavior.[120]

Another consideration for practitioners and case workers are the limitations of the child's health insurance. Most children in out-of-home care rely on Medicaid for mental and medical health services.[121] Even though Medicaid will reimburse up to 86 hours of mental health services per child per month, the number of available practitioners to treat foster children is low.[122] Practitioners are deterred from accepting foster children by low reimbursement rates for services and the amount of time required to properly diagnose foster children who present with complex mental health issues.[123] The result is a handful of pediatricians treating a large number of children. Given the limited number of pediatricians, one solution is to prescribe a medication to temper a child's behavioral problems while waiting for a child psychiatrist who specializes in neglect, abandonment, and sexual or physical abuse to become available.

Despite the limited number of practitioners willing to treat foster children, Florida has seen consistent and

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[119] *Treatment of Children with Mental Illness*, NATIONAL INSTITUTE OF MENTAL Health (2009), *available at* http://www.nimh.nih.gov/health/publications/treatment-of-children-with-mental-illness-fact-sheet/nimh-treatment-children-mental-illness-faq.pdf.

[120] Interview, *supra* note 23.

[121] ROB GREEN, ET. AL., THE URBAN INSTITUTE, MEDICAID SPENDING ON FOSTER CHILDREN 3 (2005), *available at* http://www.urban.org/UploadedPDF/311221_medicaid_spending.pdf.

[122] *Id*.; Interview, *supra* note 23; *Glossary*, FLORIDA MEDICAID REFORM CHOICE COUNSELING, http://www.flmedicaidreform.com/english/benefits/viewall.html#Mental_Health_Services (last accessed Nov. 14, 2010).

[123] *Id*.; Interview, *supra* note 23; Howard, *supra* note 112.

substantial growth in demand for mental health services in recent years, with little increase in funding or providers.[124] In order to meet the need for mental health services, Florida contracted with nonprofit agencies to provide child welfare services.[125] These agencies are responsible for purchasing therapeutic services not reimbursed by Medicaid for children in their care.[126] The agencies are responsible for the payment of therapeutic services from a federal grant and must monitor and report to the DCF the amount of funds spent.[127] Children in out-of-home care have a consistently high demand for these services, although researchers are uncertain if their mental health issues come from trauma prior to entering care or genetic predisposition. Although funds for therapeutic services exist, the shortage of practitioners delays treatment and increases the likelihood practitioners will prescribe a quick fix medication.[128]

Pharmaceutical companies also have an impact on the treatment children receive. Through incentive programs and sales representatives, pharmaceutical companies encourage practitioners to increase the number of prescriptions written for specific medications. Practitioners in Florida are not immune to these incentives. Last year a neurologist received trips to Spain and Scotland as compensation for prescribing a

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[124] Steering Comm. on Families & Children in the Court, *supra* note 2, at 29.

[125] *Children, Youth and Families*, FLA. DEP'T OF CHILDREN & FAMILIES, http://www.dcf.state.fl.us/programs/cbc/ (last accessed March 16, 2011).

[126] FLA. DEP'T OF CHILDREN & FAMILIES, 100800 FUNDS ELIGIBILITY AND ALLOWABLE EXPENDITURES (2010), *available at* http://www.dcf.state.fl.us/programs/cbc/docs/2010_11/General/100800%20Funds%20Eligibility%20and%20Allowable%20Expenditures%20Doc%202010_06_21.pdf (last accessed March 16, 2011).

[127] *Id*.

[128] Steering Comm. on Families & Children in the Court, *supra* note 2, at 29 (citing Legislative Committee on Intergovernmental Relations, 2005); *Mental Health Services*, FLA. DEP'T OF CHILDREN AND FAMILIES, http://www.dcf.state.fl.us/programs/samh/mentalhealth/CMHfunded.shtml (last accessed Dec. 6, 2010); Associated Press, States Wrestle with Medicating Foster Kids, MSNBC (March 13, 2007), http://www.msnbc.msn.com/id/17597241/ns/health-mental_health/.

large number of a specific medication[129] and a Florida psychiatrist wrote 96,685 prescriptions for mental health drugs in a 21-month period.[130] These promotions are beneficial to Medicaid providers who receive low contracted rates for services and encourage irresponsible prescription practices. The preceding discussion is not a comprehensive list of the factors influencing the possible treatments a child may receive. Florida should strictly monitor the psychotropic medication process and the number of prescriptions written by mental health practitioners, to prevent the overmedicating of foster children.

III. The Legal Process of Administering Psychotropic Medications to Children in Out-of-Home Care

> *"In Florida a detailed framework of safeguards protecting foster children exists and is articulated in statute, administrative rules and operating procedures.[131] The failures in the system however stem from lack of compliance with this framework and with failures in communication, advocacy, supervision, monitoring, and oversight."*[132]

When there is evidence that a child has been abused, neglected or abandoned the child may be placed in the custody of the DCF. Children put in the custody of DCF are known as foster children.[133] The placement and care of foster children in Florida is accomplished through contracts with private

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[129] David Sessions, *Psychotropic Drug Abuse in Foster Care Costs Government Billions*, POLITICS DAILY (Nov. 2010), http://www.politicsdaily.com/2010/06/17/psychotropic-drug-abuse-in-foster-care-costs-government-billions/?a_dgi=aolshare_email.

[130] Mark Cabra and John Dorschner, *Another Volley in Rx Probe*, MIAMI HERALD, Oct. 21, 2010, *available at* http://www.miamiherald.com/2010/10/21/1883536/another-volley-in-rx-probe.html. This comes out to about 153 prescriptions per day assuming he worked on weekends and took no vacations.

[131] *Report of Gabriel Myers Work Group*, *supra* note 1, at i.

[132] *Id*.

[133] FLA. STAT. ANN. § 39.401 (1)-(5).

agencies,[134] which DCF supervises.[135] Statutes, guidelines, and administrative codes all work together to make up the legal process for administering psychotropic medication to foster children. Case managers must be familiar with the legal process to best serve the children under their care.

When the state takes on the role of a parent, case managers become the go-between, coordinating services and ensuring compliance with state laws and provider guidelines. Unless a parent or legal custodian's rights have terminated, the state continues to look to the parent or legal guardian to be involved in the child's health decisions, including the administration of psychotropic medication.[136] Unfortunately, for many children in out-of-home care receiving psychotropic medication, their parents either refuse to participate in their care or their parental rights were terminated.[137] When this happens, case managers must drive children to and from appointments, communicate information, and initiate the medication consent process.[138]

A. Who Attends Medical Appointments

Although it is the state's goal for the parent, legal guardian, or caregiver[139] to attend all medical appointments,

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[134] Community-Based Care is a comprehensive redesign of Florida's Child Welfare System. It combines the outsourcing of foster care and related services to competent service agencies with an increased local community ownership of service delivery and design. This innovative statewide reform increases accountability, resource development, and system performance. *Children Youth and Families: About Community Based Care*, FLA. DEPT. OF CHILDREN & FAMILIES, http://www.dcf.state.fl.us/programs/cbc/ (last accessed Nov. 15, 2010).

[135] *About the Department of Children & Families*, FLA. DEPT. OF CHILDREN & FAMILIES, http://www.dcf.state.fl.us/about/ (last accessed Nov. 15, 2010).

[136] FLA ADMIN. CODE ANN. r. 65C-35.007(1) (2010).

[137] Gabriel Myers Workgroup, *Psychotropic Medication Review*, *supra* note 14.

[138] GABRIEL MYERS WORKGROUP, *Meeting Minutes*, *supra* note 109; FLA. ADMIN. CODE ANN. r. 65C-35.003(1)-(2) (2010).

[139] In the context of this paper a caregiver is a person approved in writing by the Department of Children and Families, responsible for providing the child's daily needs. FLA. ADMIN. CODE ANN. r. 65C-35.001(3).

there is no statute or code requiring them to do so.[140] The case manager or child protection investigator (hereinafter CPI) must accompany the child when the parent, legal guardian, or caregiver cannot attend.[141] A case manager may juggle the transportation of 20 children to doctor appointments, therapy, family visits, and home visits.[142] Even the most organized case manager may end up "double booked." When this occurs, another case manager or transporter, unfamiliar with the child, may fill in for him or her.[143] The alternate case manager or "fill in" may not have the Resource Record or any medical history to give the practitioner.[144]

After the appointment, the case manager is responsible for conveying information to the child's parent, legal guardian, or caregiver. The purpose of this conversation is for the case manager to obtain the legally required consent or to enable the party to properly administer prescribed psychotropic medication.[145] Following this discussion, the case manager is required to summarize the conversation in the Florida Safe Families Network.[146] This summary includes the name of the prescription, the prescribing physician, the quantity, and the dose of medication.[147]

There are problems with the medication consent process. DCF offers a standard Medical Report form for the practitioner to use in obtaining consent and assent prior to the administration of psychotherapeutic medication, but its use is

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[140] FLA. ADMIN. CODE ANN. r. 65C-35.003(1)-35.004(1) (2010).
[141] *Id*.
[142] Gabriel Myers Work Group, *Meeting Minutes*, *supra* note 10, at 14; Rene Stutzman, *More Than 70 Florida Caseworkers Lied About Efforts to Protect Children*, THE ORLANDO SENTINEL, (2009) (case managers generally average 14-22 children), *available at* http://www.orlandosentinel.com/news/local/orl-florida-child-welfare-workers-lied-071209,0,3634483.story.
[143] Gabriel Myers Workgroup, *Meeting Minutes*, *supra* note 110, at 5; Interview, *supra* note 23.
[144] *Id*.
[145] FLA. ADMIN. CODE ANN. r. 65C-35.003(2) (2010).
[146] FLA DEP'T OF CHILDREN & FAMILIES, *supra* note 89, at 3-5, 3-6.
[147] FLA. ADMIN. CODE ANN. r. 65C-35.007(5) (2010).

not mandatory.[148] Since practitioners can choose to use their own form in lieu of the standard form, there is potential for incomplete documentation and mistakes. Additionally, if the information is not entered immediately after conversing with the parent or caregiver, the FSFN system may not contain an adequate summary.[149] This can negatively impact quality assurance monitoring and administration oversight. Finally, using a 'fill in' case manager with little to no relationship or information about the child is especially concerning. Without consistent, reliable information, practitioners with limited information about a child are essentially thwarted from making an accurate assessment of the child's functioning.[150]

B. Obtaining Assent from the Child

Understanding that children should be involved in their own care, Florida requires practitioners to discuss recommended treatment with the child at an age appropriate level.[151] The focus of the conversation is to garner the child's assent to the proposed treatment.[152] The practitioner must note that the conversation occurred and the child's response.[153]

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[148] FLA. ADMIN. CODE ANN. r. 65C-35.013(1) (2010); FLA. DEPARTMENT OF CHILDREN AND FAMILIES FORM CF-FSP 5339 (Jan. 2010), *available at* http://www.dcf.state.fl.us/DCFForms/Search/DCFFormSearch.aspx (enter form number where noted; then search).

[149] *Q&A with George Sheldon, Secretary of Florida's Department of Children and Families*, NATIONAL CONFERENCE OF STATE LEGISLATURES, http://www.ncsl.org/?tabid=19001 (We are implementing a mobile computing system so all case managers can document their visits to children in foster care with a photo that is stamped with the time, date and location. The system allows case managers to do their "paperwork" online in the field, giving them more time to work with children and families and cutting back time in the office).

[150] Am. Acad. of Child and Adolescent Psychiatry, *supra* note 2, at 5S.

[151] FLA. ADMIN. CODE ANN. r. 65C-35.005(1) (2010).

[152] *Id*. (assent is a obtained by a process by which a provider of medical services helps the patient achieve a developmentally appropriate awareness of the nature of his or her condition; informs the patient of what can be expected with tests and treatment; makes a clinical assessment of the patient's understanding of the situation and factors influencing how he or she is responding; and solicits and expression of the patient's willingness to accept the proposed care).

[153] FLA. ADMIN. CODE ANN. r. 65C-35.005(3) (2010).

Obtaining the child's assent allows the practitioner to understand the child's feelings about the proposed treatment.[154] While the assent of a child of sufficient maturity is important, it does not fulfill "express and informed consent,"[155] as required under Florida law prior to the administration of psychotropic medication. If the child is uncomfortable with the plan after the discussion, the practitioner may consider revising the plan.[156] The discussion between the practitioner and child should include:

> (a) Alternative treatment options;
> (b) The method of administering the medication;
> (c) An explanation of the nature and purpose of the treatment;
> (d) The recognized side effects, risks and contraindications of the medication;
> (e) Drug-interaction precautions;
> (f) Possible side effects of stopping the medication;
> (g) How treatment will be monitored; and
> (h) The physician's plan to reduce and/or eliminate ongoing administration of the medication.[157]

In the event a child refuses to assent to the proposed treatment plan and the practitioner is unwilling to change his recommendation, the child has legal options.[158] The child's case manager may request the appointment of an attorney to represent the child in a hearing as to the necessity of the administration of psychotropic medication.[159] Unfortunately, no evidence exists to verify that children receive notice of proposed treatments or acquire information on how to object

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[154] *Id*.
[155] FLA. ADMIN. CODE ANN. r. 65C-35.005(3)(a) (2010).
[156] *Id*.
[157] FLA. ADMIN. CODE ANN. r. 65C-35.005(2)(a)-(h).
[158] FLA. ADMIN. CODE ANN. r. 65C-35.005(3)(b).
[159] *Id*.

to such treatments.[160] While experts and the legislature agree that children are best helped through their own involvement in their medical treatment, in practice, a lack of oversight may undermine this important requirement.

C. Obtaining Express and Informed Consent

There are two ways to gain consent for the administration of psychotropic medication to a child in out-of-home care. First, the parent or legal guardian of the child can consent to the administration until their parental or custodial rights terminate.[161] Second, DCF can seek a court order for the administration of psychotropic medication to the child.[162] The consent must be both express and informed, as defined in the Florida Administrative Code.

> [V]oluntarily written consent from a competent person who has received full, accurate, and sufficient information[163] and explanation about a child's medical condition, medication, and treatment to enable the person to make a knowledgeable decision without being subject to any deceit or coercion. . . [164]

A foster parent or caregiver with whom the child resides may attend medical appointments and express their concerns about the recommendation of psychotropic medication. However, foster parents and caregivers are prohibited from providing express and informed consent for

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[160] *Report of Gabriel Myers Work Group*, *supra* note 1, at 24.
[161] FLA. ADMIN. CODE ANN. r. 65C-35.005(3)(a), 35.007(1) (2010).
[162] *Id*.
[163] *Id*. r. 35.001(10) (Sufficient explanation includes but is not limited to the following information provided and explained in plain language by the prescribing physician to the consent giver: the medication, reason for prescribing it, and its purpose or intended results; side effects, risks, and contraindications, including effects of stopping the medication; method for administering the medication, and dosage range when applicable; potential drug interactions; alternative treatments; and the behavioral health or other services used to complement the use of medication when applicable).
[164] *Id*.; FLA. STAT ANN. § 394.455(9) (2010).

the administration of psychotropic medication.[165] Only parents and legal guardians have the authority to give express and informed consent. Unless their rights are terminated, the child's case manager must relay information gained during medical appointments to the parent or legal guardian in order to obtain the legal consent required. One study showed that in 59% of the cases, case managers did not attempt to contact the parent or guardian.[166]

D. Obtaining a Court Order

If DCF or an appointed guardian *ad litem* believe medication is in the best interest of the child and medically necessary the department must obtain a court order to gain consent, if the child's parent is either not involved or the parental rights were terminated.[167] To obtain a court order, the department must submit to the court a motion indicating their intent to treat the dependent with a psychotropic medication.[168] This information at a minimum should include:

> 1. The name of the child, the name and range of the dosage of the psychotropic medication, and that there is a need to prescribe psychotropic medication to the child based upon a diagnosed condition for which such medication is being prescribed.
> 2. A statement indicating that the physician reviewed all the provided medical information concerning the child.
> 3. A statement indicating that the psychotropic medication, at its prescribed dosage, is appropriate for treating the child's diagnosed medical condition, as well as the behaviors and symptoms the medication, at its prescribed dosage, is expected to address.

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[165] FLA. ADMIN. CODE ANN. r. 65C-35.004(1) (2010).
[166] Gabriel Myers Work Group, *Meeting Minutes*, *supra* note 10, at 9.
[167] FLA. STAT ANN. § 39.01(51) (2010); FLA. ADMIN. CODE ANN. r. 65C-35.009(1)- (4) (2010)
[168] FLA. ADMIN. CODE ANN. r. 65C-35.007(2)(2010).

> 4. An explanation of the nature and purpose of the treatment; the recognized side effects, risks, and contraindications of the medication; drug-interaction precautions; the possible effects of stopping the medication; and how the treatment will be monitored, followed by a statement indicating that this explanation was provided to the child if age appropriate and to the child's caregiver.
> 5. Documentation addressing whether the psychotropic medication will replace or supplement any other currently prescribed medications or treatments; the length of time the child is expected to be taking the medication; and any additional medical, mental health, behavioral, counseling, or other services that the prescribing physician recommends.[169]

The motion to the court must include three additional items: 1) a written report of the department's attempts to help the practitioner obtain express and informed consent from the legal guardian or parent to administer psychotropic medication,[170] 2) alternative treatments considered,[171] and 3) include the practitioner's signed medical report.[172]

After compiling the necessary information, the department is obligated to inform all parties of its intent to administer psychotropic medication to the child within 48 hours of filing the motion with the court.[173] If no party objects to the department's motion, the court may authorize the administration of psychotropic medication without a

[169] FLA. STAT. ANN. § 39.407(3)(c)1-5 (2010).
[170] FLA. ADMIN. CODE ANN. r. 65C-35.007(9) (2010); FLA. R. OF JUV. P. § 8.355(1)(A) (2008).
[171] FLA. R. OF JUV. P. § 8.355 (2008).
[172] *Id*. § (1)(B).
[173] *Id*. § (2).

hearing.[174] When the court desires additional information, it may order medical consultation or require a second opinion.[175]

Ideally, the information obtained will be accurate and comprehensive, allowing all parties to understand the child's need for medication based on specific events and a thorough mental health assessment. In the event a party[176] desires to challenge the department's motion, they may file an objection within two working days after notification of the department's motion.[177] If a party objects, the court must hold a hearing as soon as possible on the department's motion.[178]

The court order is not equal to express and informed consent by a parent. Essentially, when parents are no longer involved in the treatment decisions of their child, a judge, who is knows little about the child, may order the administration of psychotropic medication. A judge makes this decision based on the complex information presented to the court. By removing the child from the court's view, judicial consent creates an illusion that the judge's order to medicate a child and risk negative side effects is not significant.[179] A judicial Steering Committee on Families and Children found the authorizing of psychotherapeutic medications to children in foster care presents further legal and ethical concerns worthy of review.[180] The Steering Committee went on to recommend training in psychotherapeutic medication for judges in juvenile

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[174] *Id*. § (b)(1).
[175] FLA. ADMIN. CODE ANN. r. 65C-35.012(2) (2010).
[176] In this context a party could be DCF, the appointed guardian *ad litem*, a representative for the guardian *ad litem* and the child. The child's parents are also parties to the action but for the focus of this paper they are either not involved or their rights are terminated. FLA. STAT. ANN. § 39.01(51) (2010).
[177] FLA. STAT. ANN. § 39.000 (2010).
[178] *Id*.
[179] Gabriel Myers Workgroup, *Meeting Minutes*, *supra* note 110, at 13 (Judges have clearly indicated a lack of real knowledge of how to proceed with the judicial approval of the prescription of these kinds of medications); Steering Comm. on Families & Children in the Court, *supra* note 2, at 86.
[180] Steering Comm. on Families & Children in the Court, *supra* note 2, at 23.

court and hiring board-certified child psychiatrists to review and approve all psychotherapeutic medication requests.[181] When Florida is the parent, it is likely a judge will follow the practitioner's recommendations for psychotropic medication since roughly 61% of foster children receive psychotropic medication consent from a court order.[182]

There can be no doubt that Florida has a system in place for the administration of psychotropic medication to children. However, the system is not concise or easily accessible as it draws from Florida's statutes, administrative code and guidelines from DCF. The system's pitfalls arise from a lack of communication, funding, and human error.

IV. What Other States Are Implementing

Florida is not the only state questioning the administration of psychotropic medication. A report conducted by the Government Accountability Office indicated that 15 states had concerns about the overprescribing of psychotropic medication to foster children.[183] When compared to children nationally, there is increasing concern about the large variation of psychotropic medication use in foster care children.[184] This concern prompted the Fostering Connections to Success and Increasing Adoptions Act, Public Law 110-351, which requires child welfare agencies in each state to provide ongoing oversight of psychotropic medications.[185] Although not the sole reason states are

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[181] *Id*. at 29.
[182] Gabriel Myers Work Group, *Psychotropic Medication Review*, *supra* note 14.
[183] *Child Welfare: Additional Federal Action Could Help States Address Challenges in Providing Services to Children and Families: Hearing Before the Subcomm. on Income Security and Family Support of the H. Comm. On Ways & Means*, 110th Cong. 2 (2007) (Statement of Cornelia M. Ashby, Director of Education, Workforce, and Income Security Issues) *available at* http://www.gao.gov/new.items/d07850t.pdf.
[184] Zito testimony, *supra* note 7.
[185] Laurel K. Leslie, et al., *Multi-State Study on Psychotropic Medication Oversight in Foster Care*, Tufts Clinical and Translational Science Institute, 2-4 (Sept. 2010) *available at* http://www.tuftsctsi.org/About-Us/Announcements/~/media/23549A0AA4DE4763ADE445802B3F8D6F.

reviewing their current processes, the law certainly prompted some to action.[186]

A. Tennessee

Tennessee came under scrutiny in 2000, when a class action was filed on behalf of foster children.[187] The class action concerned the inappropriate administration of psychotropic medication to children while under state care.[188] This case raised questions that led Tennessee to reinvent how the state monitors psychotropic medication.[189] Tennessee established a database to monitor the administration of psychotropic medication to children in state custody and created medication administration guidelines.[190] Uniquely, Tennessee is one of three states where licensed health care professionals consult and provide consent for psychotropic

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ashx; Public Law 110-351 sec 205, (2008) *available at* http://www.fosteringconnections.org/tools/assets/files/Public_Law_110-351.pdf.

[186] *Id*.

[187] Brian v. Bredesen, 2009 U.S. Dist. LEXIS 112890 (M.D. Tenn. Dec. 4, 2009).

[188] *Managing Psychotropic Medication Usage in a Child Welfare System: Hearing Before the Subcomm. on Income Security and Family Support of the H. Comm. On Ways & Means*, 110th Cong. 2d sess. (2008) (testimony of Tricia Lea, PH.D., Director of Medical and Behavioral Services, Dep't of Children's Serv.), *available at* http://www.aphsa.org/home/doc/APHSA_NAPCWATestimony0520.pdf.

[189] Best Practice Guidelines, *Behavioral Health Services for Children and Adolescents:* Ages 6-17, TENN. DEP'T OF MENTAL HEALTH AND DEV. DISABILITIES, Division of Clinical Leadership, 6, 39 (July 2007), available at http://www.tn.gov/mental/omd/clinical_docs/bpg.pdf; TENN. DEP'T OF CHILDREN'S SERV., *Psychotropic Medication Utilization Parameters For Children in State Custody, 2-3, available at* http://www.state.tn.us/youth/dcsguide/policies/chap20/PsychoMedUtilGuide.pdf (adapted from Texas Dep't of State Health Services).; Children's Rights, *Tenn. Foster Care Report: Significant Improvements in Key Areas, But Serious Problems Remain* (Sept. 18, 2007), *available at* http://www.childrensrights.org/news-events/press/tennessee-foster-care-report-significant-improvements-in-key-areas-but-serious-problems-remain/.

[190] Micheal W. Naylor et al., *Psychotropic Medication Management for Youth in State Care: Consent, Oversight, and Policy Considerations*, CHILD WELFARE, September/October 2007, 175-192.

medication requests[191] when the rights of a parent or legal guardian terminate.[192]

Tennessee created guidelines for prescribing practitioners to use when recommending psychotropic medication.[193] They adapted these guidelines from the Texas parameters with only minor adjustments.[194] In 2008, Tennessee began using TNKIDS,[195] a statewide automated child welfare information system that supports social workers in their case management to track children on psychotropic medication.[196] The system uses the medication guidelines to automatically email the Department of Children Services (DCS) chief medical officer, alerting her that a prescription falls outside of the guidelines.[197] Tennessee employed nurses to work as consultants with DCS by "adding notes to TNKIDS health section, monitoring data, entering paid claims data from the managed care company that covers children in custody and pharmacy data."[198] This information essentially creates a

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[191] *Id*. at 175-192, table 1.

[192] Children's Rights, Ten*nessee Foster Care Report: Significant Improvements in Key Areas, But Serious Problems Remain* (Sept. 18, 2007), http://www.childrensrights.org/news-events/press/tennessee-foster-care-report-significant-improvements-in-key-areas-but-serious-problems-remain/ (The lawsuit filed by Children's Rights, resulted in a settlement in 2001 with Tennessee's Department of Children's Services agreeing to meet specific improvements within 7 years).

[193] Child Welfare League of America: CHILDRENS VOICE, November/December 2009, http://www.cwla.org/voice/0811national.htm (last visited Oct. 30, 2010).

[194] *Id*.

[195] Univ. of Tenn., Social Work Office of Research and Pub. Serv., STIMULUS, Winter 1999, 10. http://www.csw.utk.edu/about/stimulus/fall98.pdf (last visited Oct. 30 2010) (For example, using the TNKIDA database, a child who enters foster care at age 3 could be followed from on cse manager to another and across county lines, even if the child stays in care for several years, moves to different foster homes, and eventually is adopted. Information about the length of stay, number of placements, and other vital data will be systematically updated).

[196] *Id*.

[197] Child Welfare League of America, *supra* note 193.

[198] *Id*.

health summary that is customizable for appointments, court hearings, and meetings similar to the Texas health passport.[199]

Like Florida, Tennessee requires parental consent prior to the administration of psychotropic medication to a minor child, unless the parental rights have terminated. Exceptions to the parental consent requirement are divided into two groups: children over 16 and children under 16.[200] When parental rights have terminated, or the child is 16 years of age or older,[201] Tennessee allows the child to dictate the amount of parental involvement in psychiatric appointments and medication decisions.[202] In the event that parental rights are terminated, and the child is under 16, the DCS Regional Nurse is responsible for consent.[203] The DCS Regional Nurse must receive notification of all medication changes such as dosage and discontinuation.[204] Having a nurse review and consent to the medication allows Tennessee to make up for the lack of parental concern by applying the cautiousness of a medical professional.

B. Texas

Texas, like Tennessee, implemented changes in the way it monitors the administration of psychotropic medication to children in out-of-home care. After conducting a Child Protective Services review,[205] Texas created Psychotropic Medication Utilization Parameters for Foster Children[206] and

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[199] *Id*.
[200] TENN. DEP'T OF CHILDREN'S SERV., *Informed consent*, Admin. Policies and Procedures 20.24, *available at* http://www.tn.gov/youth/dcsguide/policies/chap20/20.24.pdf (Current Effective Date: DCS 20.24 01/15/10).
[201] *Id*.
[202] TENN. DEP'T OF CHILDREN'S SERV., *supra* 200; TENN. CODE ANN. § 33-08-202(a) (2000).
[203] TENN. DEP'T OF CHILDREN'S SERV., *supra* 200.
[204] *Id*; TENN. CODE ANN. § 33-08-202(a) (2000).
[205] DEP'T OF FAMILY & PROTECTIVE SERV., *Renewal Initiatives*, http:/www.dfps.state.tx.us/About/Renewal/CPS/medical.asp (last accessed Dec. 5, 2010).
[206] TEX. DEP'T OF STATE HEALTH SERV., *Psychotropic Medication Utilization Parameters for Foster Children*, 2, *available at*

hired a single healthcare company whose medical advisory committee monitors healthcare provider performance.[207] These changes resulted in a decrease in the number of foster children on psychotropic medication, even with an increase in foster children since their implementation.[208] Texas' STAR Health program implemented the Medical Home concept and a Health Passport. The Health Passport ensures each child has a primary care provider to oversee their care and ensure that medication information is available to doctors even when a full medical record is not.[209] The Texas legislature subsequently passed changes to the Texas Family Code, which resulted in the creation of a medical consenter.[210]

The medical consenter is a court authorized individual, who after completing an approved training program, may consent to medical care for a foster child.[211] This person may be the child's foster parent, the child's parent, the department, or an agent of the department.[212] However, if it is in the child's best interest, the court retains the authority to independently issue an order related to the medical care of a foster child.[213] The designated "medical consenter" should participate in each appointment of the child.[214] The medical consenter is responsible for ensuring the Health Passport is available to the practitioner at every appointment.

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http://www.dshs.state.tx.us/mhprograms/pdf/PsychotropicMedicationUtilizationParametersFosterChildren.pdf.

[207] DEP'T OF FAMILY & PROTECTIVE SERV., *supra* note 205.

[208] Texas Health & Human Serv. Comm'n., *Update on the Use of Psychoactive Medications in Texas Foster Children Fiscal Years 2002-2009,* http://www.hhsc.state.tx.us/medicaid/OCC/Psychoactive_Medications.html (last accessed Dec. 5, 2010).

[209] DEP'T OF FAMILY & PROTECTIVE SERV., *supra* note 205.

[210] DEP'T OF FAMILY & PROTECTIVE SERV., *Medical Consent,* http://www.dfps.state.tx.us/About/Renewal/CPS/medical_consent.asp (last accessed Dec. 5, 2010).

[211] TEX. FAM. CODE ANN. § 266.004(a), (b)(1), (h) (2007).

[212] *Id*. § (b)(1)-(2).

[213] *Id*. § (g).

[214] *Id*. § (i).

Texas' Health Passport was created to ensure medical information follows each child, wherever they go. The passport travels with each child, even when the child moves or leaves state care.[215] The information in a medical passport may include;

> (1) The name and address of each of the child's physicians and health care
> providers;
> (2) A record of each visit to a physician or other health care provider, including
> routine checkups conducted in accordance with the Texas Health Steps program;
> (3) An immunization record that may be exchanged with ImmTrac;
> (4) A list of the child's known health problems and allergies;
> (5) Information on all medications prescribed to the child in adequate detail to
> permit refill of prescriptions, including the disease or condition that the medication treats; and
> (6) Any other available health history that physicians and other health care providers who provide care for the child determine is important.[216]

This is similar, with the exception of immunizations, to Florida's paper Resource Record, which is maintained by the child's caregiver and is located where the child resides.[217]

In accordance with the American College of Physicians recommendations, Texas insists that all foster children have a medical home.[218] A medical home allows one

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[215] DEP'T. OF FAMILY & PROTECTIVE SERV., *supra* note 205.
[216] TEX. FAM. CODE ANN. § 266.006(b)(1)-(6) (2007).
[217] FLA. ADMIN. CODE ANN. r. 65C-001(20); Interview, *supra* note 23.
[218] TEX. FAM. CODE ANN. § 266.003(3)(2007) (provides identification of a medical home for each foster child on entering foster care at which the child will receive an initial comprehensive assessment as well as preventive treatments, acute medical services, and therapeutic and

practitioner assisting in referrals and working with specialists to monitor a child's mental and physical health.[219] The medical home is just one of the changes Texas implemented but it is an important one for a state trying to ensure sufficient care for out-of-home children.

C. Where the Sunshine State Shines

Florida has created safeguards to protect the best interest of the child. Moreover, Florida is one of only ten states where a policy exists to oversee consent for psychotropic medication.[220] Once a child in out-of-home care is administered psychotropic medication, DCF then informs the court at each review hearing of the child's medical and behavioral status.[221] DCF will present copies of new medical records generated since the previous hearing to both the court and the parties involved.[222] The court, at its discretion, may "order the child welfare agency to obtain a second opinion" or "consultation with the MedConsult line at the University of Florida."[223]

To ensure compliance with psychotropic medication procedures and administration, case managers and child protective investigator supervisors continuously review cases of children that receive psychotropic medications.[224] Additionally, supervisors have the authority to grant second opinion requests, once the child's case manager or CPI brings forth a request.[225]

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rehabilitative care to meet the child's ongoing physical and mental health needs throughout the duration of the child's stay in foster care).

[219] American College of Physicians, *What is the Patient-Centered Medical Home?*, http://www.acponline.org/running_practice/pcmh/understanding/what.htm (last accessed Nov. 14, 2010).

[220] Naylor et al., *supra* note 190, at 175-192.

[221] FLA. ADMIN. CODE ANN. r. 65C-35.007(8) (2010); Naylor et al., *supra* note 190.

[222] *Id*.

[223] Naylor et al., *supra* note 190.

[224] FLA. ADMIN. CODE ANN. r. 65C-35.011(8) (2010).

[225] FLA. ADMIN. CODE ANN. r. 65C- 35.012(1).

A pre-consent review is required when two or more psychotropic medications are prescribed to a foster child 10 years of age or younger.[226] The pre-consent review completion is the responsibility of the child's case manager and is required when medication is prescribed to improve mood, behavior problems, or mental illness.[227] A child psychiatrist contracted with the department, usually the UNF MedConsult, will review the prescribing practitioner's psychotherapeutic medication treatment plan and determine if the proposed medication regimen is consistent with accepted medical practice.[228]

Florida understands the importance of a child's awareness of his or her own medical issues and proposed treatments. Requiring prescribers to communicate and obtain age appropriate assent, Florida created procedures that acknowledge the rights of children to understand their medical care. Additionally, the Gabriel Myers Workgroup continues to monitor the administration of psychotropic medications to children in out-of-home care and supervise quality assurance of data entered into the FSFN.

Upon entering out-of-home care, all children from birth to age 17, who are Medicaid eligible, by meeting requirements such as residency and income limits, are required to receive a Comprehensive Behavioral Health Assessment.[229]

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[226] GABRIEL MYERS WORK GROUP, *supra* note 1, at 8; DEP'T OF CHILDREN AND FAMILIES, CF Operating Procedure No. 175-98; Pre-Consent Review for psychotherapeutic Medication Treatment Plan for Children From Birth Through Age 5 In Out Of Home Placement.

[227] CF Operating Procedure No. 175-98, *supra* note 226.

[228] *Id*; Letter from Alan Abramowitz, State Director, Office of Family Safety *available at* http://centerforchildwelfare.fmhi.usf.edu/kb/policymemos/New%20requirements%20for%20pre_consent%20review%20of%20PsyMeds%20for%20children%20in%20OHC_final%20signed.pdf.

[229] "Currently, the child welfare pre-paid plan pays for two (2) assessments per year per child at $210 per assessment, bringing the assessments to an annual amount of $420 ($210/assessment times 2) per child. The estimated number of children in out-of-home care on psychotropic medication, but who are not on the child welfare prepaid plan, is 924." GABRIEL MYERS WORK GROUP, STRATEGIC INITIATIVES, 19, (Jan. 31, 2010), *available at*

The assessment provides information about the child's psychological health and its effect on social behavior.[230] When provided, the assessment allows case workers and practitioners to recognize potential mental and behavioral health problems and implement treatment in a timely manner.[231]

Foster children are banned from participating in clinical drug trials.[232] After the death of Gabriel Myers, legislatures attempted to implement the ban by amending Florida's Statutes, but the bill did not pass in the House.[233] Undeterred, the ban was added to Florida's Administrative Code in mid-2010.[234] While some may see the ban as preventing foster children from receiving necessary treatment, others see the participation of foster children in drug trials as exploitation.[235]

Like Texas, Florida is working toward implementation of the medical home concept. Hillsborough County, Florida was recently recognized as a Star Community by Champions Inc., a national center "designed to support communities in organizing services for families of children and youth with special health care needs," for their excellence in organizing services for families.[236] In Duval County, multiple organizations are working in conjunction with the Dyson

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http://www.dcf.state.fl.us/initiatives/GMWorkgroup/docs/20100110GMStrategicInitiativesAA.pdf.

[230] Comprehensive Behavioral Health Assessments, 2-2, *supra* note 89.

[231] Comm. on Early Childhood, Adoption, and Dependent Care, *supra* note 91.

[232] Pareesha Narang, *Florida Bans Foster Children from Clinical Drug Trials*, Psych News, Aug. 6, 2010, http://www.psychsearch.net/psych_news/?p=1251.

[233] Carol Marbin Miller and Marc Caputo, *Effort to Protect Children from Overmedication Fails*, Miami Herald, Apr. 30, 2010, *available at* http://www.miamiherald.com/2010/04/30/1605341/effort-to-protect-children-from.html.

[234] Narang, *supra* note 232.

[235] *Id*.

[236] Am. Acad. of Pediatrics, *National Center for Medical Home Implementation*, http://www.medicalhomeinfo.org/state_pages/florida.aspx#data (last visited Oct. 30, 2010).

Initiative to "implement a Residency Program in Pediatrics and Community Health" where "residents will be introduced to the social, political, cultural, environmental, and behavioral determinants of child health."[237] The Residency Program will better prepare practitioners to deal with the dynamics involved in treating children in out-of-home care.[238] In Miami, the Dyson initiative will create an advocacy program to improve the health of children by establishing partnerships between pediatricians and community-based organizations.[239] The goal of these programs is to empower pediatric professionals to improve the health of children in their communities.[240]

D. Recommendations

Florida's efforts to improve the health of foster children are commendatory. However, changes must be made to the medication consent process to ensure another child does not die from poor oversight. Despite the positive aspects of the Florida system, to fully realize a child's best interest, Florida must make changes to the current process. Children in out-of-home care do not have a single consistently informed adult responsible for their care. Any number of adults can potentially accompany a child in out-of-home care to his or her medical appointments. This creates the potential for inadequate information exchange and prevents case managers from having the most updated information about a child's prescribed psychotropic medications. There should be one person designated to attend medical appointments with a child, a medical advocate.

An advocate would be responsible for transporting the child to appointments, attending appointments, updating side effects, noting changes in behavior, monitoring medication logs, counting medication pills, and ensuring the child assented to the medication. This would relieve case managers of these responsibilities and allow them to better monitor each child's case. By designating one person to oversee the child's

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[237] *Id.*
[238] *Id.*
[239] *Id.*
[240] *Id.*

medical needs and report adverse side effects, the state could ensure effective responsiveness to changes in the medical needs of the child[241] and relieve a burden on case managers. The bill proposed by Senator Storms recommended the medical advocate be a guardian *ad litem*.[242] Volunteers could fill the role of a medical advocate. For example, students entering a social work program might constitute a good selection pool.

Florida could emulate Tennessee and create a behavioral health review team made up of nurses or licensed mental health practitioners for each district to review cases that fall outside of the established prescribing guidelines. For example, the behavioral health review team could review treatment plans for children who are prescribed more than one medication from the same class (e.g., two anti-psychotic medications).[243] Currently in Florida, it is up to the prescribing practitioner to fall within recommended medication guidelines.[244] Supervisors may review complex cases, but there is no guaranteed review of the proposed medication regimen to see if it falls within medication guidelines.[245] Even though Florida's MedConsult is available to case managers, DCF staff, Children's Legal Services, parents and guardian ad item guardians or attorneys, it is most often accessed by the guardian *ad litem* program.[246] Unfortunately, not every child in the foster system has a guardian *ad litem* to advocate on his or her behalf.[247]

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[241] *Report of Gabriel Myers Work Group*, *supra* note 1, at 25.
[242] Session Bill 724. Florida House of Representatives; Accessed: Saturday, October 23, 2010, http://www.myfloridahouse.gov/sections/Bills/billsdetail.aspx?Billid=42669.
[243] TENN. DEP'T. OF CHILDREN'S SERV., Medication Monitoring Guidelines, 2.
[244] Univ. of South Florida, *Recommended Guidelines*, http://flmedicaidbh.fmhi.usf.edu/recommended_guidelines.htm (last accessed Nov. 15, 2010).
[245] FLA. ADMIN. CODE ANN. r. 65C-35.011(3) (2010); Interview, *supra* note 23.
[246] Gabriel Myers Work Group, *Meeting Minutes*, *supra* note 10.
[247] *Id*.

Florida must recruit more mental health practitioners, especially those specializing in sexual abuse, neglect, and abandonment, who are willing to participate in the Medical Home concept. Every child should have a single pediatrician who coordinates and oversees his or her care. In one study, the case manager failed to coordinate with the pediatrician to obtain a psychiatric evaluation in 78 of the 112 cases reviewed.[248] While Florida is amenable to the idea of a Medical Home for foster children, implementation has not yet occurred. It would be in the child's best interest to have a sole pediatrician work with case managers to coordinate preventive treatments and ensure compliance with treatment plans.[249]

The Medical Home provides patients personal attention and enables the physician to catch gaps in care to provide better outcomes for patients.[250] The foundations of the medical home include: a health care provider who is accessible 24 hours a day, provide service locations near the child, consider cultural background, maintain a sole primary health provider, and provide coordinated and comprehensive preventive care. The goal is to manage the cost of medical care by improving the quality of care and reducing trips to the emergency room.[251] By working with pediatricians as

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[248] Gabriel Myers Work group, *Meeting Minutes*, 2 (June 18, 2009), *available at* http://www.dcf.state.fl.us/initiatives/GMWorkgroup/docs/meeting061809/20090618meetingminutes.pdf.

[249] *Prescription Psychotropic Drug Use Among Children in Foster Care*, *supra* note 7, 38-39 (Testimony of Laurel K. Leslie, on behalf of the American Academy of Pediatrics).

[250] East Tennessee Medical News, *Patient-Centered Medical Home Puts Patients at the Center of Healthcare Reform*, http://www.easttnmedicalnews.com/news.php?viewStory=1819 (last accessed Dec. 8, 2010).

[251] *Id.*; GABRIEL MYERS WORK GROUP, CONFUSION AMONG PHYSICIANS REGARDING THE USE OF PSYCHOTROPIC MEDICATIONS, http://www.dcf.state.fl.us/initiatives/GMWorkgroup/docs/meeting072409/July24presentationChiaro.pdf; Partnership for Child Health, THE PARTNERSHIP CONNECTION, Vol. 5, No. 5 June 2010, *Why you need to consider becoming a medical home practice now*, 2, *available at* http://www.partnershipforchildhealth.org/publications.htm (Select June under subheading 2010).

partners, providers could ultimately reduce the cost of future medical care by ensuring children get the services they need in a timely manner.

To provide better care to foster children, a practitioner must have access to the child's Resource Record. The Resource Record is required to "contain copies of all available and accessible medical and psychological information (including behavioral health information) pertaining to the child."[252] Informing both care givers and medical personnel treating the child is a step in the right direction; unfortunately, the Resource Record is in paper format. This means that copies of updated information must pass between case managers, practitioners, and caregivers during home visits and appointments, before being placed in the Resource Record. Passing around paper leaves room for human error in the maintenance of the Record. Resource Records should be available online, and accessible to the caregiver, parent, case manager, case manager's supervisors, and practitioners ensuring up to date information for those responsible for the child's care. A growing number of computerized medical records are under development and implemented to make specific health information more accessible.[253] Florida needs to select one of these computerized medical record services.

Once the child begins taking the psychotropic medication, the department must rely on the caregiver administering the medication to do so correctly.[254] Caregivers are to report on a medication log: "the child's name, name of the medication, prescribed dosage and administration intervals, the dates and times of administration, and must initial the log after monitoring each administration."[255] The Department of Children and Families or their service providers are to develop locally approved medication logs, with room for caregivers to report any

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[252] FLA. ADMIN. CODE ANN. r. 65C-35.001(20) (2010).
[253] Comm. on Early Childhood, Adoption, and Dependent Care, *supra* note 91; Open Clinical Electronic Medical Records, http://www.openclinical.org/about.html (Feb. 15, 2010).
[254] *Report of Gabriel Myers Work Group*, *supra* note 1, at 21.
[255] DEP'T OF CHILDREN & FAMILIES, *supra* note 89, at 3-14.

complaints the child may have about the medication, side effects or noted behavior changes.[256] Each month, a case manager should notate in the medication logs and count the medication. However, monthly review is not frequent enough to ensure compliance with dosage requirements.[257] Children could miss doses or sell their medication to classmates during a month's period without the case manger's knowledge.[258] To check the medication log more frequently, such as weekly, a caregiver should have the ability to enter this information into an online database. Entering online would ensure information preservation and case managers should have access to the medication log at any time to ensure compliance with dosage requirements. Alternately, a medical advocate, who accompanies the child to various medical appointments, gives information to practitioners and discusses information with caregivers, could oversee the medication log on a biweekly basis.

There is a relationship between behavioral issues and placement failures.[259] A 2009 special review of placement stability found that 39% of placements failed due to the child's ungovernable behaviors.[260] If permanency is a goal, then the caregiver needs access to additional support. While keeping children with their family is ideal,[261] it is not always possible, and the foster children need stability. To improve the possibility of a stable placement, the state could monitor placements on a rating system to determine potential failures. Additional options to increase stability include parenting

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[256] FLA. ADMIN. CODE ANN. r. 65C-35.011(7) (2010).
[257] *Id.*; Interview, *supra* note 23.
[258] Author's antidote from experiences as a guardian *ad litem*.
[259] David M. Rubin, et al., *Placement Stability and Mental Health Costs for Children in Foster Care*, 113 PEDIATRICS 1336 No. 5 (May 2004).
[260] DEP'T OF CHILDREN & FAMILIES, *Placement Stability Review Report*, 5 (Aug. 2009), *available at*http://centerforchildwelfare.fmhi.usf.edu/kb/prprouthome/Placement%20Stability%20Report%208%202009.pdf.
[261] DEP'T OF CHILDREN & FAMILIES, *Research Supports Keeping Children with Their Families*, *available at* http://www.dcf.state.fl.us/initiatives/fostercare/docs/ResearchFACTSHEET111909.pdf.

classes, behavior modification therapy, support groups, or family therapy. A foster parent support system may reduce both the number of placement failures and medicated children, as both the child and caregiver learn together how to cope with behavioral issues.[262]

Conclusion

> *"[Jacob was diagnosed with ADHD and prescribed Ritalin. The Ritalin helped with the hyperactivity but it made him anxious.] And so then we'd end up giving him a second medication to deal with the anxiety. And then the second medication would cause something else, some compulsive behavior or a tic. And then they'd say, "OK, give him a third thing." And so finally- it was like that whole- there was an old lady who swallowed the fly. And then the she had to swallow the spider to get rid of the fly. And then she had to swallow a mouse to get rid of the spider. That's was what the meds were like. By age ten Jacob had been given eight different medications."*[263]

For years Florida has been like the old lady who swallowed a fly, attempting to bandage failures in its psychotropic medication process, instead of making proactive changes. In 2003, the State became aware of the increasing rate of psychotropic medication prescriptions to foster children when the Florida Statewide Advocacy Council submitted the Red Item Report on Psychotropic Drug Use in Foster Care.[264] However, it took the tragic 2009 death of Gabriel Myers to prompt a dramatic increase in the oversight of the administration of psychotropic medication to children in out-of-home care.

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[262] Rubin, *supra* note 259.
[263] FRONTLINE, *The Medicated Child*, (PBS broadcast 2008), *available at* http://www.pbs.org/wgbh/pages/frontline/medicatedchild/view/ (chapter 1).
[264] Gabriel Myers Workgroup, *Meeting Minutes*, *supra* note 10.

Children in out-of-home care often experience trauma or abuse at the hands of their parents. They are often hurt, confused, and scared of the future. Children need love and support in a stable family and instead, they receive multiple psychotropic medications and a referral for therapy in order to stabilize the placement. Even with the crackdown on oversight, the need for change in the administration of psychotropic medications is apparent. By phasing in new procedures and technology, that proved effective in other states, Florida can better serve the children under its care.

To better serve out-of-home children, the state must seek new and innovative ways to monitor the administration of psychotropic medication to foster children. By reviewing and selecting processes from other states, Florida can apply proven processes to protect children in state care. Medical advocates can protect foster children from unnecessary medications or to ensure the child understands the need for and agrees to take medication. Treatment review by mental health professionals offers an unbiased look at whether the child's medications fall within best practice guidelines. Allowing a group of unbiased mental health practitioners to determine consent removes the decision from a sole judge to that of a specialized group creating an additional protection for the child. Outside of the medication consent process, Florida could ensure children receive timely and thorough care by increasing the number of pediatricians contracted to oversee treatments and referrals for foster children. Additionally, the implementation of secure interactive electronic medication logs and Resource Records will ensure pertinent information is updated and accurate. While these changes may never replace the cautiousness of a prudent parent, they can shield Florida's children from the ambivalent use of potentially dangerous psychotropic medications.