Testimony of

Bryan Samuels, Commissioner

Administration on Children, Youth and Families

Administration for Children and Families

U.S. Department of Health and Human Services

Before the

Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security

Senate Committee on Homeland Security and Governmental Affairs

United States Senate

December 1, 2011

Chairman Carper, Ranking Member Brown, and members of the Subcommittee, thank you for the opportunity to testify before you this morning about the use of psychotropic medications among children in foster care. First, I would like to acknowledge the leadership demonstrated by Congress in this area already, most recently in the reauthorization of title IV-B of the Social Security Act. In September, Congress acted on an Administration proposal to provide HHS with additional authority in the Child and Family Services Improvement and Innovations Act of 2011 (Public Law 112-34) to require States to address the trauma needs of children and to develop protocols for monitoring the use of psychotropic drugs among children in foster care. Other notable Congressional work includes the passage of the Fostering Connections to Success and Increasing Adoptions Act, which requires the use of medical homes and oversight of prescription medications for children in foster care, and the recent work of the Senate Caucus on Foster Youth, led by Senators Landrieu and Grassley, to highlight the issue of psychotropics. In 2009, the Subcommittee on Income Security and Family Support of the House Committee on Ways and Means held a hearing on prescription psychotropic drug use among children in foster care. Additionally, I would like to thank this Committee for requesting that the Government Accountability Office review the use of psychotropics with children in foster care, as it has produced a comprehensive and useful report that can help guide ongoing action. As I have noted, much work has occurred already, and the hearing today furthers this critical conversation. Together, this work will advance the child welfare and mental health fields and truly benefit some of the most vulnerable children in our society.

During my testimony, I will address critical issues related to the use of psychotropic medication among children in foster care and outline the activities that the Department of Health and Human

Services (HHS) has undertaken to improve oversight and monitoring. It is impossible to discuss the use of psychotropics without addressing the impact of maltreatment on the overall social and emotional well-being of children who have experienced abuse or neglect. HHS is examining and responding to issues of psychotropic drug use within this context with the goal of building the capacity of child welfare systems to both identify the needs of children and youth who have been maltreated and deliver effective, evidence-based interventions to meet those needs. Certainly this includes strengthened protocols for the prescription and monitoring of psychotropic medications; more broadly, though, it requires that child welfare systems have increased ability to deliver effective psychosocial interventions, such as Trauma-Focused Cognitive-Behavioral Therapy, as treatment strategies alone or, when appropriate, in conjunction with pharmaceutical treatments to improve the well-being of the children and youth that they serve. Such a focus on social and emotional well-being increases the likelihood that children who enter foster care exit to reunification, guardianship, or adoption sooner and better equipped to become healthy, contributing adults.

When I became the Director of the Illinois Department of Child and Families Services (DCFS) in 2003, the State had seen a dramatic reduction in the number of children in the foster care system. However, our data indicated that the children who were in the State's custody exhibited significant emotional and behavioral problems. There was no question as to the need for intervention and treatment to address the complex needs resulting from the maltreatment these children had experienced. At the same time, biological, foster, and adoptive parents shared with me the concerns that they had with regard to the psychotropic medications with which their children were treated. Many felt that these drugs were being overprescribed and were causing adverse side-effects, such a sedation, weight gain, and attention problems. A common sentiment

among these parents was that they lacked the expertise to make decisions about psychotropic medications or monitor their use and side-effects in their children. Their concerns were representative of the lack of capacity in the child welfare system to understand and oversee pharmacological treatment of children's behavioral and psychological issues. During my tenure as Director, DCFS developed a comprehensive system of protocols and safeties to ensure that psychotropic medications are prescribed responsibly and monitored consistently. This included:

- requiring that all prescriptions be reviewed and approved at the State Deputy Director level;
- establishing time-limits for reviews to ensure that necessary treatment was not delayed;
- developing an electronic database for tracking all prescriptions for children in foster care;
- creating "red flags" in the database that elevated certain cases, such as those in which three or more medications were prescribed, for more thorough review; and
- establishing best practice guidelines and distributing them to prescribers. The electronic database was also designed to identify providers whose patterns of prescribing differed from the guidelines.

The net result of these activities was greater longitudinal oversight of the pharmacological treatment of young people in foster care. We collected better data on how psychotropic medications were being used among this population, and important safety checks were established to ensure that use was appropriate and responsible.

OVERVIEW

Over the last decade and a half, the child welfare system has become 27 percent smaller, declining from 559,000 children in 1998 to just over 400,000 in 2010.[1] Nearly all States have

been able to reduce the number of children in foster care significantly by providing necessary support services to families to prevent children from coming into care, and, when they do come into care, moving them more quickly to permanent placements, such as reunification, guardianship, or adoption. However, as the system continues to decrease in size, the children who have remained in foster care are more likely to have emotional and behavioral problems that hinder healthy functioning and make it difficult to achieve permanency. Children who experience the trauma of maltreatment have complex needs and require a comprehensive set of services to overcome the social and emotional impact of abuse and neglect to be successful in life. As the child welfare system continues to reduce in size, it must concurrently build the capacity to identify the repercussions of maltreatment and deliver effective interventions that facilitate healing and recovery.

Social-emotional, behavioral, and mental health needs of children in child welfare

Children who come to the attention of the child welfare system have disproportionally high rates of social-emotional, behavioral, and mental health challenges. When examining rates of mental health diagnoses or behavior problems requiring clinical intervention, it becomes clear that the impacts of abuse and neglect on child and adolescent functioning are profound. A key source of information about the social and emotional well-being of and use of psychotropic medications with children who have experienced maltreatment comes from the *National Survey of Child and Adolescent Well-Being* (NSCAW), a longitudinal study required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 and overseen by the Administration on Children and Families. NSCAW has been the source of invaluable information about how children who have been maltreated are doing over time and across domains – in school, at home, as they receive services, and as they become adults. Although it provides high-quality data that

directly informs the work of child welfare and mental health providers, the continuation of this important survey is at risk. Without ongoing funding from Congress, we will lose our best window into the lives of children who experience maltreatment.

NSCAW and other sources of information about the well-being of children and youth known to child welfare demonstrate the impact of maltreatment on social-emotional, behavioral and mental health:

- 23 percent of children 17 and under who have experienced maltreatment have behavior problems requiring clinical intervention. Clinical-level behavior problems are almost three times as common among this population as among the general population.[2]
- 35 percent of children 17 and under who have experienced maltreatment demonstrate clinical-level problems with social skills – more than twice the rate of the general population.[3]
- Both internalizing problems (e.g., depression, anxiety, being withdrawn) and externalizing problems (e.g., aggression, delinquency) are common in children who have experienced maltreatment. Among children who enter foster care, approximately one third have clinical-level behavior problems.[4]
- Children in foster care are more likely to have a mental health diagnosis than other children. In a study of foster youth between the ages of 14 and 17, 63 percent met the criteria for at least one mental health diagnosis at some point in their life. The most common were Oppositional Defiant Disorder/Conduct Disorder, Major Depressive Disorder/Major Depressive Episode, Attention Deficit/Hyperactivity Disorder, and Posttraumatic Stress Disorder.[5]

- By the time they are 17, 62 percent of youth in foster care will exhibit both symptoms of mental health disorder and symptoms of trauma.[6]
- Although they make up only three percent of the Medicaid population under age 18, children in foster care account for 32 percent of the recipients of behavioral health services in this group.[7]

Psychotropic medication use among children in foster care

According to a 2010 study, children in 13 States who are in foster care and enrolled in Medicaid were prescribed antipsychotic medications at nearly nine times the rate of children enrolled in Medicaid who were not in foster care.[8] Over three years, 22 percent of children in foster care will have taken a psychotropic drug at some point.[9] Although numerous studies have demonstrated that rates of psychotropic medication prescription are high among this group, it is unclear to what extent these rates may be reflecting, at least in part, the increased distress among children who have experienced maltreatment, though other factors may also be playing a role.

Studies have shown the following, with regard to the prevalence of psychotropic drug use and factors influencing the likelihood of use among children in foster care:

- Age: Children in foster care are more likely to be prescribed psychotropics as they grow older, with 3.6 percent of 2-5 year-olds taking medication at a given time, 16.4 percent of 6-11 year-olds, and 21.6 percent of 12-16 year-olds. The likelihood that a child will be prescribed multiple psychotropic medications also increases with age.[10]

- Gender: Males in foster care are more likely to be receiving psychotropic medications (19.6 percent) than their female counterparts (7.7 percent).[11]

- Behavioral Concerns: Children scoring in the clinical range on the Child Behavioral Checklist, a common tool for assessing both internalizing and externalizing behavioral issues among children and youth, are much more likely than those with subclinical scores to receive psychotropic medications.[12]

Additionally, researchers have identified some patterns of prescription of psychotropic medication to children in foster care that may be problematic:

- Documented geographic variation in psychotropic medication use among children coming into contact with child welfare indicates that factors other than clinical need impact prescription. One study found that children in Texas were five times as likely as children in California to be taking psychotropic drugs. The varying rates of use cannot be attributed to population differences, suggesting that factors other than clinical need, such as gender and age, may be influencing the practice of prescribing psychotropic medications.[13]

- To treat the multiple mental and behavioral health symptoms that a child may exhibit, more than one drug–and often more than one type of medication–are prescribed. Among children in foster care taking psychotropic medication, 21.3 percent are receiving monotherapy (one class of psychotropic medication), 41.3 percent are taking three or more classes of psychotropics, 15.4 percent are taking medication from four or more classes, and 2.1 percent taking five or more classes of drugs.[14] Although children with histories of maltreatment often present with complex, co-morbid conditions, evidence of the effectiveness of concomitant psychotropic use is scant. There is no research to support the use of five or more psychotropic drugs, yet we know that a small number of

children in foster care are receiving medications at these levels. Further, taking multiple medications within and across classes increases the risk of adverse effects, including drug interactions.

It is clear that the current use of psychotropic medications among children, particularly children in foster care, goes beyond that which is supported by empirical research. In the absence of such research, it is not possible to know all of the short- and long-term effects, both positive and negative, of psychotropic medications on young minds.

DEPARTMENTAL ACTIVITIES

The Department of Health and Human Services (HHS) has undertaken an interagency effort to understand the unique needs of children who have experienced abuse or neglect and develop a coordinated strategy to build the capacity of child welfare systems to meet these needs. Research has demonstrated that maltreatment has long-lasting, adverse effects in all domains of development. As our understanding about the multidimensional impact of maltreatment has increased, our knowledge of effective, evidence-based treatments, both psychosocial and pharmacological, has grown as well. However, the child welfare system has lacked the capacity to incorporate this knowledge and consistently apply it to improve the lives of children who have been abused or neglected. Through ongoing, coordinated efforts across the Department to build knowledge and encourage best practices, HHS is working to build the capacity of child welfare, children's mental health, and State Medicaid systems to both recognize the social-emotional, mental, and behavioral health consequences of maltreatment and deliver a mix of services that effectively responds to the complex needs of the children they serve.

To this end, a joint letter from the Administration on Children and Families (ACF), Centers for Medicare & Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA) was sent out on November 23, 2011 to raise awareness of these issues at the State level and to share expanded opportunities that will be offered to strengthen their systems of prescribing and monitoring psychotropic medication use among children in foster care. These opportunities draw on the existing authority and resources of HHS and are part of a collaborative, Department-wide strategy to address this issue.

Additionally, a workgroup with representatives from HHS agencies- ACF, CMS, SAMHSA, the Agency for Healthcare Research and Quality (AHRQ), the Food and Drug Administration (FDA) and the National Institutes of Health (NIH) convened in the summer of 2011 with an initial task of examining the monitoring and oversight of psychotropic medications among children in foster care.

As an initial task, the workgroup gathered information about the need for mental and behavioral health services among children in foster care, as well as the use of psychotropic medications in this population. Peer-reviewed journal articles, research reports, reviews of State practices, and conversations with expert researchers and clinicians informed this process. HHS is disseminating this information widely and continues to seek emerging knowledge about the impact of maltreatment and what works to meet the complex needs of children known to the child welfare system. Additionally, HHS is funding demonstration and research projects related to the use of psychotropic medications and/or behavioral interventions for children in foster care.

Much is known about how child welfare systems can deliver more effective services to treat children and youth who have experienced maltreatment. A number of professional organizations

have built upon a wealth of empirical and practice-based evidence to create guidelines for the treatment of children known to child welfare, including the prescription and monitoring of psychotropic medications. Several States and jurisdictions have taken steps to both improve controls on psychotropic medications for children in foster care and increase their ability to identify and respond to the consequences of maltreatment. HHS is encouraging child welfare systems to learn about what works and undertake changes to implement best practices based on the existing professional guidelines and state examples, both of which are grounded in rigorous research or prior successful application. This includes the development of guidance and provision of technical assistance to States, Territories, and Tribes to support the building of capacity to recognize and respond to the needs of children who have been abused or neglected.

Future Actions

HHS has identified concrete actions in the three areas outlined above: (1) increasing oversight and monitoring of psychotropic medications, (2) expanding the evidence base for effectively responding to the needs of maltreated children, and (3) expanding the use of evidence-based screening, diagnosis, and treatment of social-emotional, behavioral, and mental health issues among children who have experienced abuse or neglect.

Expanding oversight and monitoring of psychotropic medications. HHS is strongly committed to the appropriate prescription and use of psychotropic therapies for children. In the coming months, ACF will issue guidance to States on best practices for monitoring psychotropic drug prescriptions for foster children.

State practices regarding prescription and oversight of psychotropic medications vary widely, and experts agree that greater controls are needed to ensure safe and appropriate use. According

to the Child and Family Services Improvement and Innovation Act of 2011 (P.L. 112-34), States must develop their own psychotropic medication monitoring procedures and describe them in their Child and Family Services Plans (CFSP). In advance of their 2012 Annual Plan and Services Report (APSR) submission (annual plans update and amend CFSPs, which are completed every five years), HHS will provide technical assistance, including the dissemination of guidelines developed by professional associations and information about exemplary practices in place in some States.

Additional ongoing activities will enhance psychotropic medication oversight. CMS will work with States to enhance their Drug Utilization Review (DUR) programs, which allow States to monitor dispensing at the point-of-sale, the pharmacy counter, and to influence prescriber behavior. CMS also will encourage providers to adopt, implement, upgrade, and meaningfully use Electronic Health Records (EHRs) in order to access the Medicaid and Medicare EHR incentive payments. EHRs can improve the consistency and quality of health services for children, especially those whose residences changes frequently. The development of quality health homes, standards for behavioral health, and behavioral health coverage for children and adults are among the practices that CMS will promote.

Expanding the evidence base. Efforts to expand the evidence base regarding the needs of children who have been maltreated are twofold. First, HHS is actively disseminating existing information about effective treatment of children known to child welfare, including the prescription and monitoring of psychotropic medications. Among other resources, this includes a report funded by AHRQ summarizing the findings of a 16 State consortium of State Medicaid Medical Directors developing best practices to improve the use of antipsychotic medications in children in Medicaid. Mechanisms for disseminating this and additional information about

psychotropic medications and behavioral interventions for children in foster care include webinars; a joint letter to State child welfare, Medicaid, and mental health directors from ACF, CMS, and SAMHSA; an Information Memorandum and subsequent Program Instruction to child welfare directors; and a compilation of resources on the Child Welfare Information Gateway, an online clearinghouse of materials for child welfare and related professionals.

Second, HHS is growing the evidence base by funding research and demonstration projects that investigate both client-level interventions and system strategies to improve well-being outcomes for children and families. AHRQ has contracted for an evidence review of interventions that address child exposure to familial trauma in the form of maltreatment or family violence. Meanwhile, the Administration on Children, Youth and Families (ACYF) has organized its discretionary funding to promote the social and emotional well-being of children and youth who have experienced maltreatment. For example, in FY 2011, a cluster of five grantees received a total of $3.2 million to implement evidence-based, trauma-focused practices and evaluate their impact on safety, permanency, and well-being outcomes. Findings from research and demonstration projects supported by HHS will also be widely disseminated to a variety of stakeholders.

Increasing the use of evidence-based screening, diagnosis, and treatment. Other HHS actions will serve to expand the use of evidence-based and best practices for the identification and treatment of social-emotional, behavioral, and mental health problems among children who have experienced maltreatment. HHS supports the use of evidence-based interventions by disseminating information about what works (for instance, via the National Registry of Evidence-Based Programs and Practices and the National Child Traumatic Stress Network) and providing funding for implementation of strategies grounded in rigorous research (e.g., Maternal,

Infant and Early Childhood Home Visiting Program). These practices serve to identify and assess the needs of children who are suffering from the negative effects of abuse and neglect, and to target and deliver the appropriate services to meet children's identified needs. As child welfare systems build the capacity to recognize the consequences of maltreatment with greater precision, their delivery of services will be more tailored, and therefore more effective and efficient.

Because children in foster care are involved with multiple systems, including education, health, mental health, Medicaid, and others, a coordinated, multi-system approach is necessary to meaningfully improve outcomes for this population. HHS is working to facilitate State-level collaborations for the purposes of fostering improved behavioral health diagnosis, treatment, and tracking of all children, including those in foster care. In addition to holding joint webinars and disseminating materials across systems, ACYF, CMS, and SAMHSA will, in July 2012, convene State child welfare, Medicaid, and mental health directors to develop action plans for enhancing oversight of psychotropic medications and improving well-being for children in foster care.

It should be noted that increasing the capacity of child welfare systems to conduct evidence-based screening, assessment, and treatment requires enhancing the clinical competencies of the workforce. As the research I have shared demonstrates, children who have experienced maltreatment have a complex behavioral profile requiring specialized services. In order to deliver these services, which we know can be effective, it is necessary to build the capacity of the child welfare workforce to recognize and respond to the impacts of abuse and neglect.

CONCLUSION

The research tells us that most of the children in foster care receiving psychotropic medications have legitimate needs that require careful, comprehensive intervention. There are effective treatments for the mental health disorders and trauma symptoms common among children known to child welfare, and efforts undertaken to ensure the appropriate use of psychotropics for these children must be accompanied by increased availability of evidence-based psychosocial treatments that meet the complex needs of children who have experienced maltreatment.

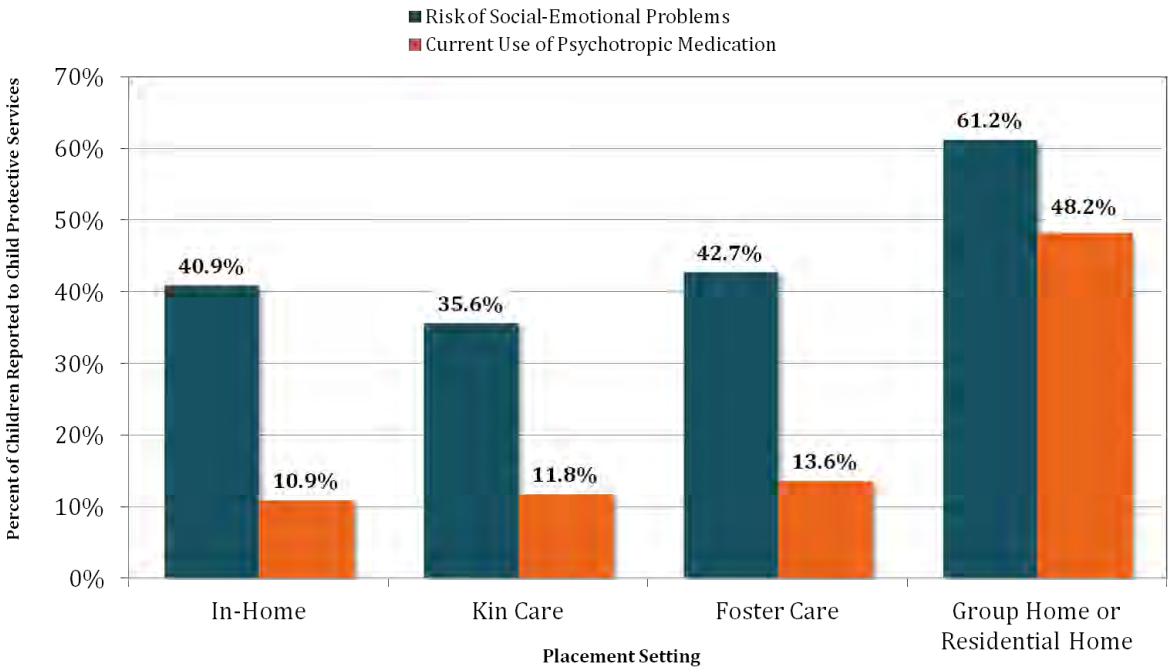
The experience of maltreatment can derail the development of a child and severely hinder his or her chances for success throughout life. However, we know that some children who have been abused or neglected do not develop the myriad problems listed above. That tells us that although children who have been maltreated face immense challenges, they are incredibly resilient. We also know that even among children who do develop social-emotional, behavioral, and mental health problems, healing and recovery are possible. With the right tools and capacity, child welfare systems can identify the complex needs of children who have experienced maltreatment and deliver targeted, evidence-based services that help young people overcome the social and emotional impact of abuse and neglect. By addressing these needs, we increase the likelihood that children in foster care will exit to positive, permanent settings, with the skills and resources they need to be successful in life. HHS is working to build the child welfare system's capacity to identify and treat the needs of maltreated children by expanding the evidence base around social-emotional well-being for children in foster care; improving oversight and monitoring of psychotropic medications among this group; and expanding the use of evidence-based screening, assessment, and treatment to promote healing, recovery, and well-being for these children.

Thank you. I look forward to working with you on these issues, and I am happy to take your questions.

---

[1] Administration for Children and Families (1998-2010). Adoption and Foster Care Analysis and Reporting System, Reports 11-18. Washington, DC: US Department of Health and Human Services.
[2] Data source: National Survey for Child and Adolescent Well-Being II
[3] Ibid.
[4] Ibid.
[5] White, CR; Havalchak, A; Jackson, L; O'Brien, K; & Pecora, PJ. (2007). Mental Health, Ethnicity, Sexuality, and Spirituality among Youth in Foster Care: Findings from The Casey Field Office Mental Health Study. Casey Family Programs.
[6] Griffin, G; McClelland, Holzberg, M; Stolbach, B; Maj, N; & Kisiel, C (In Press). Addressing the impact of trauma before diagnosing mental illness in child welfare. *Child Welfare.*
[7] Center for Health Care Strategies, Inc. (Forthcoming). Analysis of Medicaid Claims Data for 2005.
[8] Crystal, S; Olfson, M; Huang, C; Pincus, H; & Gerhard, T. (2009). Broadened use of atypical antipsychotics: Safety, effectiveness, and policy challenges. *Health Affairs.* 28(5):770. (http://content.healthaffairs.org/content/28/5/w770.full.html)
[9] Leslie, LK; Raghavan, R; Zhang, J; & Aarons, GA. (2010). Rates of psychotropic medication use over time among youth in child welfare/child protective services. *Journal of Child and Adolescent Psychopharmacology.* 20(2):135.
[10] Raghavan, R; Zima, BT; Anderson, RM; Leibowitz, AA; Schuster, MA; & Landsverk, J. (2005). Psychotropic medication use in a national probability sample of children in the child welfare system. *Journal of child and adolescent psychopharmacology*. 15(1):97.
[11] Ibid.
[12] Ibid.
[13] Raghavan, R; Gyanesh, L; Kohl, P; & Hamilton, B. (2010). Interstate variations in psychotropic medication use among a national sample of children in the child welfare system. *Child Maltreatment.* 15(2): 121-131.
[14] Zito, JM; et al. (2008). Psychotropic medication patterns among youth in foster care. *Pediatrics*. 121(1): e157.

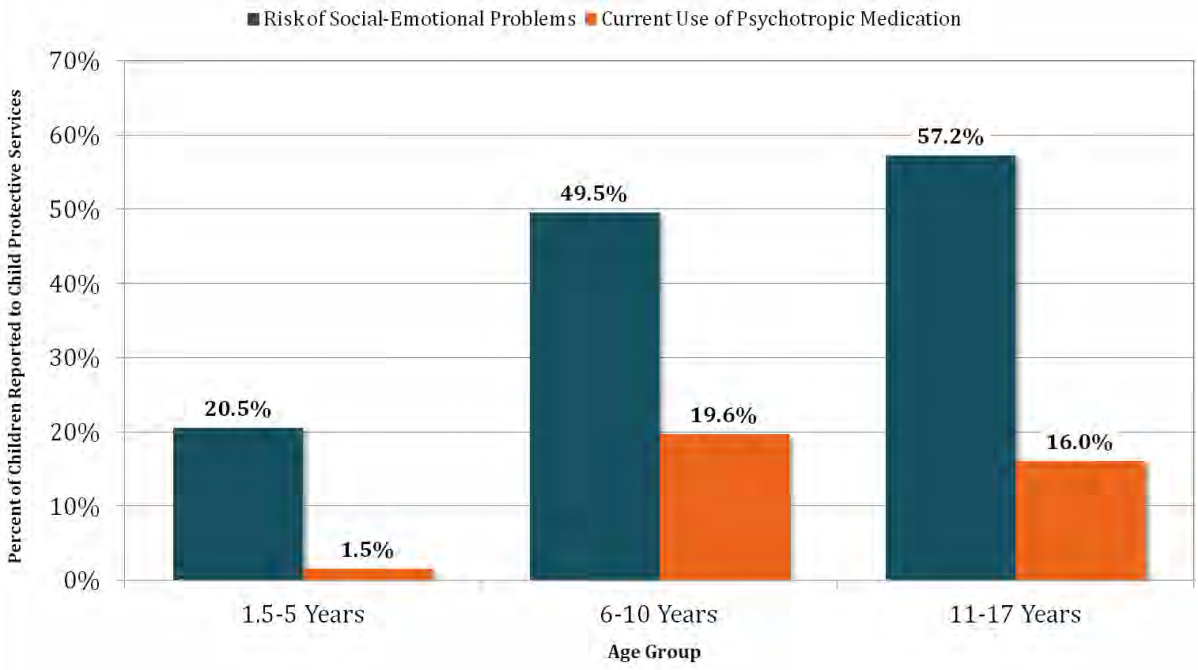
Risk of Social-Emotional Problems and Use of Psychotropic Medication, by Placement Setting



Data Source: National Survey of Child and Adolescent Well-Being II (NSCAW II). NSCAW II is a Congressionally required study sponsored by the Office of Planning, Research and Evaluation, Administration for Children and Families (ACF), U.S. Department of Health and Human Services (DHHS).

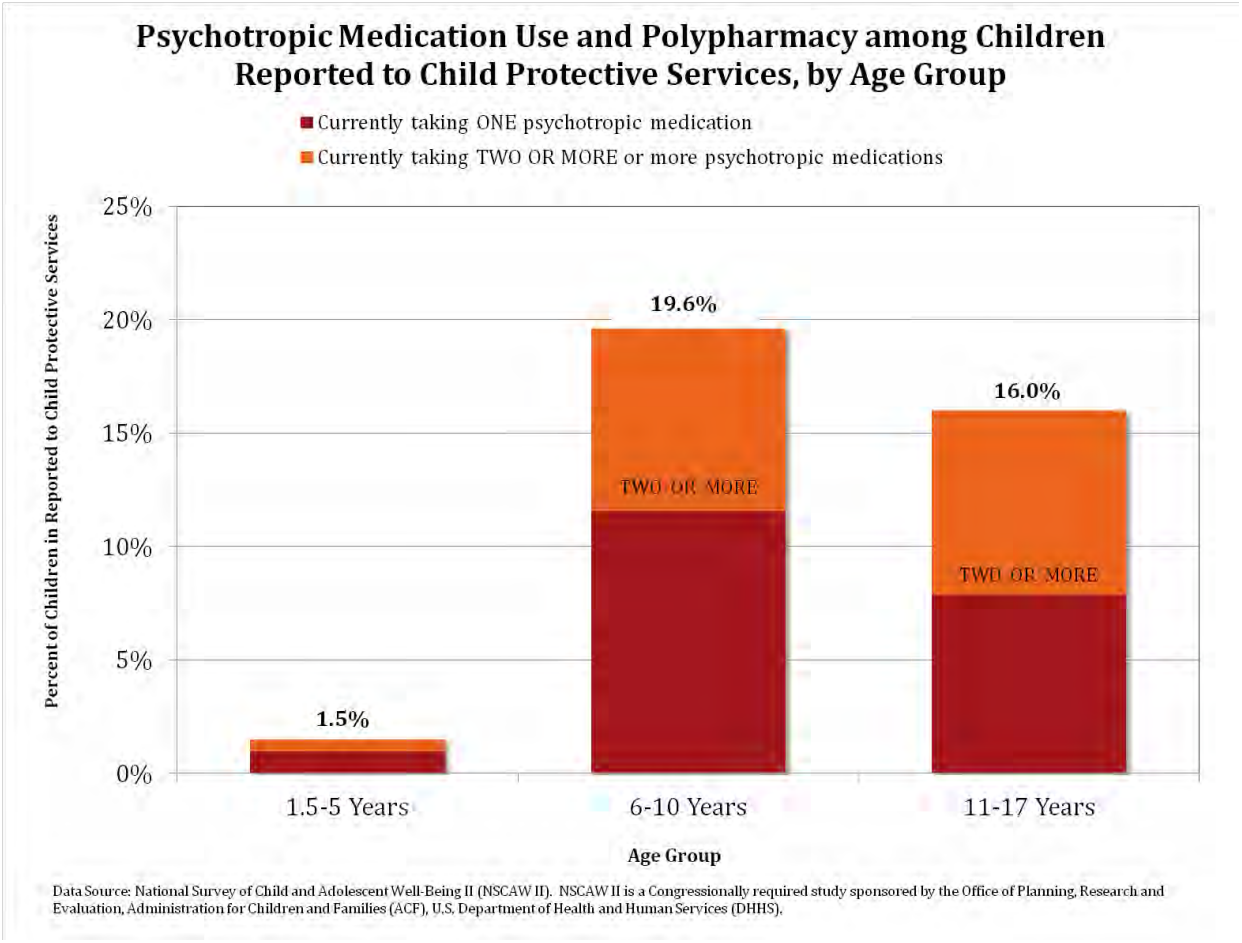
Risk of social-emotional problems was defined as scores in the clinical range on any of the following standardized measures: Internalizing, Externalizing or Total Problems scales of the Child Behavior Checklist (CBCL; administered for children 1.5 to 18 years old), Youth Self Report (YSR; administered to children 11 years old and older), or the Teacher Report From (TRF; administered for children 6 to 18 years old); the Child Depression Inventory (CDI; administered to children 7 years old and older); or the PTSD section Intrusive Experiences and Dissociation subscales of the Trauma Symptoms Checklist (administered to children 8 years old and older).

Risk of Social-Emotional Problems and Use of Psychotropic Medication, by Age Group



Data Source: National Survey of Child and Adolescent Well-Being II (NSCAW II). NSCAW II is a Congressionally required study sponsored by the Office of Planning, Research and Evaluation, Administration for Children and Families (ACF), U.S. Department of Health and Human Services (DHHS).

Risk of social-emotional problems was defined as scores in the clinical range on any of the following standardized measures: Internalizing, Externalizing or Total Problems scales of the Child Behavior Checklist (CBCL; administered for children 1.5 to 18 years old), Youth Self Report (YSR; administered to children 11 years old and older), or the Teacher Report From (TRF; administered for children 6 to 18 years old); the Child Depression Inventory (CDI; administered to children 7 years old and older); or the PTSD section Intrusive Experiences and Dissociation subscales of the Trauma Symptoms Checklist (administered to children 8 years old and older).


Psychotropic Medication Use and Polypharmacy among Children Reported to Child Protective Services, by Age Group
Currently taking ONE psychotropic medication
Currently taking TWO OR MORE or more psychotropic medications
Percent of Children in Reported to Child Protective Services
25%
20%
15%
10%
5%
0%
19.6%
16.0%
1.5%
TWO OR MORE
TWO OR MORE
1.5-5 Years
6-10 Years
11-17 Years
Age Group
Data Source: National Survey of Child and Adolescent Well-Being II (NSCAW II). NSCAW II is a Congressionally required study sponsored by the Office of Planning, Research and Evaluation, Administration for Children and Families (ACF), U.S. Department of Health and Human Services (DHHS).