Eliot Spitzer
Governor

NEW YORK STATE
OFFICE OF CHILDREN & FAMILY SERVICES
52 WASHINGTON STREET
RENSSELAER, NY 12144

Gladys Carrión, Esq.
Commissioner

Informational Letter

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To:	Commissioners of Social Services Executive Directors of Voluntary Authorized Agencies OCFS Facility Directors
Issuing Division/Office:	Strategic Planning and Policy Development
Date:	February 13, 2008
Subject:	The Use of Psychiatric Medications for Children and Youth in Placement; Authority to Consent to Medical Care
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Filing References, if applicable

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
		18 NYCRR 441.15 18 NYCRR 441.17(g) 18 NYCRR 441.22	SSL 383-b FCA 355.4 NY Penal Law 70.20(4)(b)&(c) MHL 81 MHL 33.21(e) PHL 2504.1	Working Together: Health Services for Children in Foster Care	See References list

I. Purpose

The purpose of this Informational Letter is to provide guidance on the safe and appropriate use of psychiatric medications for children and youth in the custody of OCFS, local social services district commissioners or voluntary agencies who have been placed in an out-of-home setting. The guidance presented is consistent with current research and professional publications that address psychiatric medication and children. For further information, a list of references is included in this document.

This Informational Letter also provides information on the authority to provide routine and informed consent for medical care of children in placement.

II. Background

Children in care often have biological, psychological, and social risk factors that predispose them to emotional and behavioral disturbances. These may include a family history of mental illness, in utero exposure to alcohol or drugs, medical illnesses, a history of abuse and neglect, disrupted attachments, and exposure to violence in the home or community. Additionally, the stress experienced by families as they address the child's mental illness may be a contributing factor to the child's placement in care. For many of these children, medication has been identified as an integral component of a comprehensive mental health treatment plan.

Psychiatric Medications, also called psychotropic, psychoactive or behavioral medications, are chemical substances that act primarily upon the central nervous system where they alter brain function, resulting in temporary changes in perception, mood, consciousness and/or behavior. They are used to treat the symptoms associated with mental health disorders such as attention deficit-hyperactivity disorder (ADHD), psychosis, depression, and anxiety.

The advent of symptom-targeted medications for mental illness has had a significant impact on patients, physicians, medical practice and society. Physicians have tools for treatment that are effective, enabling some individuals with debilitating symptoms to function in the community. Additionally, the stigma of mental illness has decreased. Since the introduction of lithium in the 1940's, the pharmaceutical industry has produced an array of psychiatric medications. The availability of multiple medications that address specific symptoms allows prescribers considerable latitude in choosing a medication or combination of medications to produce the desired outcome while minimizing undesirable effects. But these practices also raise concerns about the impact of psychiatric medications on children's developing brains and bodies.

Scientifically controlled double-blind studies, the "gold standard" for research, have shown that psychiatric medications are generally safe and effective for adults. However, many psychiatric medications have not undergone clinical trials with children to prove their efficacy, safety, and long-term impact. The Food and Drug Administration (FDA) determines whether a medication is safe and effective prior to approving it for marketing. Though pharmaceutical companies cannot market medications for a use not indicated by the FDA, physicians may prescribe the medication for "off-label" use. "Off-label" refers to the use of drugs for patient populations or conditions other than those for which the FDA has "approved" them as "safe and effective." This does not necessarily mean that these medications are not safe and effective for this population (Malkin, 2005). For these reasons, care must be taken in prescribing and administering psychiatric medications for children and youth, particularly in regard to "off-label" use of such medications.

III. Program Implications

As part of their responsibility for the safety, permanency and well-being of children and youth placed in their care, OCFS facilities, local social services districts and authorized foster care agencies are advised to provide diligent and thoughtful oversight of medical care provided, particularly in regard to the use of psychiatric medications. A suggested framework for this oversight is provided below.

Assessment

Any child being considered for psychiatric medication must have thorough medical and mental health assessments. These are completed upon the child's entry into care and at periodic intervals thereafter as set forth in 18 NYCRR 441.22.

The medical assessment is critical in that the symptoms attributed to mental illness may have a variety of causes. Conditions such as Fetal Alcohol Spectrum Disorder (FASD), lead poisoning, significant head trauma, premature birth, and substance abuse by the child may result in problems with executive functioning, cognition or emotional regulation. All medical conditions should be identified so that suitable interventions will be chosen by the medical practitioner and treatment team.

The central component of a mental health assessment is a clinical appointment with a qualified mental health practitioner. Refer to Chapter 1 of "Working Together: Health Services for Children in Foster Care" for a listing of the elements of the mental health assessment and those who would be considered qualified mental health professionals. This section is also attached herein and the entire manual is on the OCFS website.
(http://www.ocfs.state.ny.us/main/sppd/health_services/manual.asp)

The qualified mental health practitioner should be provided with the results of the medical assessment and a complete history of the child's functional status and behavior in various settings, such as the foster home or facility, school, day care center, and playground. If the child was taking psychiatric medication when he or she entered care, that prescription should be verified with the prescriber. Psychiatric medication should only be discontinued under the supervision of a medical practitioner, as side effects can result from the sudden cessation of some medications.

To accurately determine the impact of new medications, baseline functioning is best assessed by the administration of a pre- and post-symptom scale (e.g., Connors' Rating Scales for attention deficit hyperactivity disorder, Overt Aggression Scale for aggression, Children's Depression Inventory for depression). If this is not practical, it is recommended that the frequency and severity of target symptoms be quantified before and after the medication has been added. In addition to measurements of mental health symptoms, baseline information is also needed on the child's physical health status (e.g., weight, blood pressure, blood tests) to determine the impact of the medication.

Diagnosis

The mental health assessment may result in a diagnosis with corresponding numerical codes from the multi-axial system outlined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). This system organizes each psychiatric diagnosis into five levels (axes) relating to different aspects of the disorder or disability:

Axis I – clinical disorders, including major mental disorders, as well as developmental and learning disorders

Axis II – underlying pervasive or personality conditions, as well as mental retardation

Axis III – medical conditions which may be relevant to the understanding and treatment of the mental disorder

Axis IV – psychosocial and environmental factors contributing to the disorder

Axis V – Global Assessment of Functioning (GAF) on a scale of 100 to 0

A DSM diagnosis is a helpful starting point in understanding the child's behavior, mood, cognition, and adjustment. However, it may be difficult to formulate an accurate diagnosis of mental illness in children based on the DSM. Children may not fit the symptom criteria established for adults for certain disorders, such as bipolar. The developmental changes experienced by children as well as their malleability can make a stable diagnostic label hard to come by. Additionally, the trauma experienced by many children prior to placement as well as issues such as disrupted attachments, school problems, and substance abuse may result in a presentation which points erroneously toward mental illness.

For these reasons, treatment of children with psychiatric medication should focus on the relief of undesirable symptoms (Malkin, 2005). Accurate diagnosis can be a guide to treatment, but the effectiveness of the medication regimen is best determined by the alleviation of targeted symptoms with minimal undesirable side effects.

Behavioral Planning

Many children and youth in out-of-home placements present behavioral challenges for their caregivers at some point. Assisting the child in adjusting to placement and managing emotions and behavior is integral to well-being. The mental health assessment is an important tool in identifying the child's strengths and past traumas, and a thorough assessment should include treatment recommendations that can be incorporated into a behavioral plan. This plan could include strategies such as a tiered reward system, play therapy, trauma work, sensory integration exercises, or recreational activities. The behavioral plan should be incorporated into the Family Assessment and Service Plan (FASP).

Psychiatric medication may be part of the plan. These medications may assist the child in managing strong emotions, such as rage, so that he or she is better able to benefit from a treatment like cognitive behavioral therapy. They may also help the child to concentrate in school, improve peer relationships, sleep better, and enjoy life. However, because the effects of psychiatric medications on any individual cannot be guaranteed, it is important to try a variety of alternative interventions before prescribing medication. Medication should not be the sole component in the behavioral plan.

After the child's behavior and mood become stable, it is recommended that the prescriber adjust the medication dosage to the minimum dose at which the medication remains effective and side effects are minimized. Attempts may also be made to discontinue the medication (Bellonci, 2006; Irwin, 2002), as the child may have benefited sufficiently from alternative interventions to function well without medication. This practice reinforces the development of coping, anger management and problem-solving skills, and builds the child's sense of control and self-reliance. It also assists in determining the soundness of initial diagnostic impressions. As diagnoses can have lasting consequences, it is important to determine if the child is accurately diagnosed with a mental illness that is alleviated with medication, or if the presenting problems can be explained and addressed in other ways.

Communication Protocols

Clear communication protocols are important when a child is taking psychiatric medications. The decision to treat a child with psychiatric medications should be made in consultation with the parent or guardian and a team that should include the caseworker, caregivers, health care coordinator, agency staff with oversight responsibilities, pediatrician, and psychiatrist. The

team must carefully balance the risks of medication with the anticipated benefits.

Drug information sheets should be provided to caregivers and the parent or guardian as soon as reasonably possible. Caregivers will need detailed instructions on administering the medication. They also need to know what to expect from the medication and be alert for effects, both desirable and undesirable. Understanding the role that the medication plays in the overall treatment plan helps caregivers to comply with the regimen and monitoring requirements.

Agency policies should establish clear protocols for information sharing that include the following:

- The use of a Medication Administration Record (MAR);
- Dissemination of information to caregivers, team members and parent or guardian;
- Proactive policy for seeking and collecting information on the child's status from caregivers, school personnel, community programs, parent or guardian, and other parties that observe the child in various settings;
- Providing current information to persons administering medication outside the foster care setting (e.g., during home visits); and
- Discussion of medication during routine caseworker visits to foster homes.

General Authority to Consent to Medical Care

In accordance with New York State laws and regulations, any medical care for a child in placement must be provided pursuant to an authorized consent. Who may consent to medical care for a child in placement depends on how the child came into placement.

Article 3 (Juvenile Delinquent) Placements

Children may be placed under Article 3 of the Family Court Act (FCA) with a local social services district or with OCFS. Where a child is placed with a local social services commissioner, the regulations at 18 NYCRR 441.22(d) require the district to request authorization in writing from the child's parent or guardian for routine medical and psychological assessments, immunizations, medical treatment, and emergency medical or surgical care if the parent or guardian is unavailable when such care becomes necessary. This request must be made within 10 days after the child is taken into care. Absent consent, the local commissioner or authorized agency has no inherent authority to provide medical care. Accordingly, for those juvenile delinquents placed with a local commissioner where the parents or guardians do not consent to routine care, a court order providing appropriate authority should be sought.

Where children are placed under Article 3 of the FCA with OCFS, Section 355.4 of the FCA provides that OCFS has the authority to consent to routine medical, dental and mental health services and treatment. Thus, if a child is

adjudicated as a juvenile delinquent and placed with OCFS and OCFS then places the child with a voluntary authorized agency, OCFS would have the authority to consent to routine medical, dental and mental health services and treatment in the absence of the parent or guardian. The placement order permits administration of psychiatric medications only if such medication is part of an ongoing mental health plan that existed prior to placement with OCFS, unless the court order specifically provides otherwise.

Article 7 (Person in Need of Supervision) Placements
For children placed with a local social services commissioner under Article 7 of the FCA, the regulations at 18 NYCRR 441.22(d) require the district to request authorization in writing from the child's parent or guardian for routine medical and psychological assessments, immunizations, medical treatment, and emergency medical or surgical care if the parent or guardian is unavailable when such care becomes necessary. This request must be made within 10 days after the child is taken into care. Absent receipt of such consent, the local commissioner has no inherent authority to provide medical care, so a court order providing appropriate authority should be sought.

Article 10 (Child Protective) Placements
Where children are removed and/or placed with a local social services commissioner or voluntary authorized agency under Article 10 of the FCA, the regulations at 18 NYCRR 441.22(d) require the local commissioner or authorized agency to request authorization in writing from the child's parent or guardian for routine medical and psychological assessments, immunizations, medical treatment, and emergency medical or surgical care if the parent or guardian is unavailable when such care becomes necessary. Again, this request must be made within 10 days after the child is taken into care. If consent is not given, or pending receipt of such consent, where the child has been removed under Article 10 or placed by a court into the custody of the local commissioner of social services under Article 10, the local commissioner has the authority under Section 383-b of the Social Services Law (SSL) to give consent for medical, dental, health and hospital services for the child. Section 383-b clearly covers routine care and we understand it to also cover emergency care and non-routine care. However, it is still best to get parental consent if possible.

Juvenile Offender Placements
Where juvenile offenders are placed with OCFS under Section 70.20 of the Penal Law, the court is required to ask parents or guardians to consent to routine medical, dental and mental health services and treatment. If the parents or guardians do not consent, the commitment order is deemed to give OCFS consent for routine medical, dental and mental health services and treatment. The placement order permits administration of psychiatric medications only if such medication is part of an ongoing mental health plan that existed prior to placement with OCFS, unless the court order specifically provides otherwise.

Voluntary Placements
Where a child is placed through a voluntary placement under Section 384-a of the SSL, the placement is under such terms as are agreed to by the parties. If the placement agreement specifies terms on consent to medical care, those terms will govern. If the issue is not addressed in the agreement, the local social services district or voluntary authorized agency has no authority to consent to any sort of medical care. The best practice in voluntary placements is to be certain the issue of consents for medical care is addressed in the placement agreement.

Surrender of Parental Rights
Where there has been a surrender of parental rights under Section 383-c or 384 of the SSL, the surrender ends the parental rights of the biological parent and the biological parent has no authority to consent to any form of medical care for the child, including the administration of psychiatric medications. If both parents have surrendered their parental rights, then the local commissioner or authorized agency having guardianship of the child has full authority to consent to any medical care or procedure.

Termination of Parental Rights
Similarly, where that has been a termination of parental rights under Section 384-b of the SSL, the termination ends the parental rights of the biological parent and the biological parent has no authority to consent to any form of medical care for the child, including the administration of psychiatric medications. If the rights of both parents have been terminated, then the local commissioner or authorized agency having guardianship of the child has full authority to consent to any medical care or procedure.

Informed Consent and Capacity to Consent to the Administration of Psychiatric Medications

The authority to consent to medical care described above generally applies to routine medical care. However, for certain types of medical care or treatments, including the administration of psychiatric medications, medical practitioners will usually require informed consent. Having the authority to consent to routine medical care will not necessarily authorize OCFS, the local commissioner or the authorized agency having custody of a child to also give informed consent, as informed consent will generally be sought by medical practitioners only for non-routine care or treatments.

Informed consent requires that the person giving consent:
(1) be told details of the proposed care or treatment, such as the duration and the procedures to be followed;
(2) have the opportunity to ask questions about the proposed care or treatment; and
(3) have the risks, benefits and alternatives to the proposed care or treatment clearly explained to them.

Informed consent means that the person giving consent has been provided comprehensive information on the medication and understands the risks, benefits, and alternatives of treatment. Information should be offered in a language and terminology understood by the consenter. The person being asked to provide informed consent should be provided with written information as well as an opportunity to ask questions. Refer to Chapter 6 of "Working Together" for additional considerations. This section is also attached herein.

This leads to the question of who may issue informed consent and under what circumstances. As a general rule, prior to the administration of psychiatric medication to children in placement, informed consent must be requested from the parent or guardian. However, there are two exceptions to this general rule.

1. Pursuant to Section 2504 of the Public Health Law, a person who is 18 years of age or older, is married or is the parent of a child may give consent, including informed consent, to any medical care and treatment, including the administration of psychiatric medications. No one else is authorized to consent for care in this case unless the court has determined that the individual is incapacitated and appointed a guardian or has otherwise intervened to authorize this type of medical care.

2. If the parental rights of both parents have been surrendered or terminated, only the commissioner or authorized agency with guardianship, or the court, can give informed consent to this type of medical care. (Please note that references hereafter to obtaining the consent of the parent or guardian are inapplicable to situations where the parental rights of both parents or a guardian other than the commissioner or an authorized agency have been surrendered or terminated.)

Outside of those two situations, OCFS recommends that informed consent be first sought from the parent or guardian.

If the parent or guardian objects to the medication, OCFS, the social services district or authorized agency should:

- work with them to understand the basis of the objection,
- pursue any reasonable treatment options that the parent or guardian suggests,
- provide the parent or guardian an opportunity to meet with the prescriber and treatment team, and
- assist the parent or guardian in obtaining a second opinion, if requested.

If the parent or guardian and the treatment team cannot agree on the use of psychiatric medication, the OCFS facility, local district or authorized agency should seek legal counsel to determine if court intervention is advisable.

If the parent or guardian is unavailable or the parent or guardian does not respond to repeated requests to provide informed consent, consent may be provided in accordance with the legal placement authority.

- If the child is placed pursuant to an order or adjudication under Article 10 (child protective) of the FCA, the social services commissioner or his or her designee can provide consent.
- If the child is placed voluntarily or pursuant to FCA Article 7 (PINS), a court order must be sought to authorize the medication.
- If a youth is placed pursuant to FCA Article 3 (juvenile delinquent) in the custody of a local social services district, a court order must be sought to authorize the medication.
- If the youth is placed pursuant to FCA Article 3 in the custody of OCFS and psychiatric medications were part of an existing health care plan at the time the youth was admitted to OCFS custody, the placement order authorizes OCFS to continue the existing course of treatment without additional consent. The introduction of new psychiatric medications would require a court order.
- If a youth is placed pursuant to Penal Law 70.20 (youthful offender), a court order must be sought to authorize the medication.
- If a child is placed pursuant to a surrender or termination of parental rights, the social services commissioner or authorized agency with guardianship of the child provides consent. Parental consent is not sought.

The commissioner or designee and the court if applicable must also receive information on the medication in order to provide an informed consent.

Additionally, there are provisions in Section 33.21(e)(2) of the Mental Hygiene Law that empower a minor 16 years of age or older residing in a psychiatric hospital to consent to the administration of psychiatric medication if:

- The minor has the capacity to consent, and
- A physician determines that the medication is in the minor's best interest, and
- The parent or guardian is not available or refuses to give consent, and a psychiatrist agrees with the first physician that the child has capacity to consent and that the medication is in the minor's best interest; or requiring the consent of the parent or guardian would have a detrimental effect on the minor, and a psychiatrist agrees with the first physician that the child has capacity to consent, that the medication is in the minor's best interest, and that requiring consent of the parent or guardian would have a detrimental effect.

In cases where the parent or guardian is refusing to consent to the administration of psychiatric medication or has not made him or herself available for purposes of providing consent, the medical professional should evaluate whether the refusal or failure to be available creates reasonable cause to suspect child maltreatment for failing to provide adequate medical care and

should make a report to the Statewide Central Register of Child Abuse and Maltreatment, if appropriate.

Assent

In addition to informed consent from the parent or guardian, the assent of the child should be sought for psychiatric medications. The child needs to understand, in accordance with his or her developmental status, how the medication may impact the way he or she feels, acts, and thinks, and the benefits and risks. Older youth may be concerned about side effects such as weight gain, or being labeled with a diagnosis of mental illness. If the treatment team, caregivers, and parent or guardian have communicated well and agreed on the course of treatment, the child will receive consistent support in complying with the plan.

Where a child has the authority to give informed consent but the child does not wish to take the medication, we recommend spending some time talking with the child to understand and address his or her concerns. It may be helpful for a foster parent, caseworker, or facility staff to accompany the child to an appointment with the prescriber to help the child better understand the recommendation for medication and the risks to the child if the child does not take the medication.

When the child's condition or actions present a serious and immediate threat to personal safety, it may be necessary to administer a psychiatric medication over the child's objection on the advice of medical professionals. These circumstances should be addressed in agency policies and procedures.

Prescribing Psychiatric Medications

Ideally, psychiatric medications are prescribed by a psychiatrist (preferably specializing in child and adolescent psychiatry), psychiatric nurse practitioner, or developmental pediatrician. Given the shortage of these practitioners, medication may be prescribed by the medical home (primary care) physician if recommended as a result of the mental health assessment. The use of a psychiatrist consultant can enhance the medical home physician's ability to manage psychiatric medication regimens.

In identifying clinicians in the community to treat children in placement, we recommend seeking out those who follow the recommended prescribing principles below. If the prescriber diverges from these practices, discuss the rationale for the medication therapy with the prescriber, and request that this rationale be documented. The following list of recommended prescribing principles has been developed to assist social services districts, authorized agencies and OCFS facilities in their oversight and monitoring of psychiatric medications prescribed for children in care. ***It is not intended to dictate treatment decisions by clinicians.***

Recommended principles for prescribing psychiatric medications for children are as follows:

- Individualize medication decisions for each child.
- Identify the symptoms targeted by the medication.
- Consider the balance between benefits and risks.
- Choose medications in this order of preference, as appropriate:
    1) FDA approved for psychiatric use in children;
    2) Approved for the presenting symptoms or diagnosis in adults with evidence of effectiveness and safety in children;
    3) Approved in children for a different usage but with evidence of effectiveness and safety in children.
- Medications with more data regarding safety and efficacy are preferred over those new to the market.
- "Start low and go slow"; i.e., begin with low dosages and increase slowly.
- Allow sufficient time for the effects to be seen before increasing the dosage or determining that the medication is ineffective.
- Make only one change at a time; e.g., change a dosage or add a different medication.
- If a medication does not result in the desired effect, adjust the dosage or discontinue the medication (this must be done gradually for some medications).
- If side effects of the medication are not tolerable, try a different medication rather than adding a medication to counter the side effects.
- After the child has been stable for a period of time, medication dosages should be adjusted by the prescriber to the minimum dose at which a medication remains effective and side effects are minimized. Attempts may be made at the prescriber's discretion to discontinue the medication to determine if it is still needed.
- Explain to the child, in a developmentally appropriate manner, what to expect from the medication.

References for above list: (Bellonci, 2006; Arizona, 2006; Irwin, 2002; NYS OMH, 2004)

Monitoring

Periodic monitoring by the prescriber is necessary for all children taking psychiatric medications. Recommended monitoring includes the following:

- Clinical assessment for treatment effect;
- Clinical assessment for side effects (may include height, weight, blood pressure, involuntary movements, electrocardiogram);
- Laboratory tests as indicated for specific medication;
- Review of observations from the child, caregivers and treatment team on the effects of the medication;
- Objective evaluation of targeted symptoms, such as repeating symptom inventories or scales that were performed prior to initiation of medication; and

- Immediate communication with the child, caregivers and treatment team on recommended changes in the current medication regimen.

The frequency of medication monitoring appointments will vary depending on the medications involved and the child's condition. For example, monitoring may be needed as often as weekly if the child is unstable or many medications are involved. The medication manufacturer may recommend a monitoring schedule. If the agency has specific requirements for the frequency of psychiatric medication monitoring, these must be communicated to the prescriber, the caregivers, the treatment team and the child to support compliance.

Indicators for Independent Review

It is beneficial for districts and agencies to develop the capacity for a high-level review or second opinion by a medical expert of the medication regimen for children in placement. Circumstances that may warrant an independent review include but are not limited to the following:

- Child prescribed more than three psychiatric medications (Bellonci, 2006);
- Child prescribed more than one psychiatric medication from the same class of medications (e.g., two anti-psychotics) (Bellonci, 2006);
- Psychiatric medication prescribed for a child younger than 5 years of age (Coyle, 2000; Rey, 2000);
- Medications needed to manage target symptoms are causing significant side effects (e.g., dramatic weight gain, sleep disturbance) (Irwin, 2002; Irwin, 2004); and
- Prescribing practices vary significantly from those recommended above.

In these cases, it is recommended that the prescriber document an explanation for the recommended course of treatment and that an independent reviewer examine the mental health assessment, the presenting symptoms and behaviors, the rationale for the medications prescribed, the status of non-medication interventions, and previous medication trials. The risks of the medication regimen must be balanced against the benefits to the child in his or her unique circumstances. Long-term effects should be considered as well as immediate concerns.

Quality Assurance

A quality assurance plan is recommended to monitor the use of psychiatric medications in the out-of-home population. Agencies and districts are encouraged to develop a plan to obtain aggregate data on the use of psychiatric medications for children in their care; identify and use mental health professionals that implement the practices recommended above; and routinely review samplings of individual records. Any concerns should be addressed through a process of continuous quality improvement.

Individual record reviews should address the following questions:

- Did the child receive a comprehensive medical and mental health assessment prior to the initiation of medication?
- Have appropriate consents been obtained?
- Is there adequate communication about medication among all parties, including the child and parent or guardian?
- Has a multi-faceted behavioral plan been developed, documented and implemented?
- Are recommended prescribing and monitoring practices followed?
- Have independent reviews been conducted when indicated?
- Does documentation include the rationale for the medication regimen?
- Are clinical and laboratory monitoring reports documented, and resulting concerns addressed?

IV. Contact Persons

Questions concerning this Informational Letter may be directed to:

Buffalo Regional Office – Mary Miller	(716) 847-3145
User ID: Mary.Miller@ocfs.state.ny.us	
Rochester Regional Office – Linda Kurtz	(585) 238-8200
User ID: Linda.Kurtz@ocfs.state.ny.us	
Syracuse Regional Office – Jack Klump	(315) 423-1200
User ID: Jack.Klump@ocfs.state.ny.us	
Albany Regional Office – Glenn Humphreys	(518) 486-7078
User ID: Glenn.Humphreys@ocfs.state.ny.us	
Yonkers Regional Office – Pat Sheehy	(914) 377-2080
User ID: Patricia.Sheehy@ocfs.state.ny.us	
New York City Regional Office – Patricia Beresford	(212) 383-1788
User ID: Patricia.Beresford@ocfs.state.ny.us	
Native American Services – Kim Thomas	(716) 847- 3123
User ID: Kim.Thomas@ocfs.state.ny.us	

/s/ Nancy W. Martinez

Issued By:
Name: Nancy W. Martinez
Title: Director
Division/Office: Strategic planning and Policy Development

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ATTACHMENT

Working Together

HEALTH SERVICES FOR CHILDREN IN FOSTER CARE

Initial Mental Health Assessment

The initial mental health assessment must be conducted for children age 3 and older. It is recommended that this be completed within 30 days of placement. Although not explicitly required in NYS OCFS regulations, EPSDT [federal Early Periodic Screening, Diagnosis and Treatment standards] requires an assessment of mental health development for all Medicaid eligible children,[14] and regulations specify that psychiatric and psychological services must be made available appropriate to the needs of children in foster care.[15]

The assessment includes (1) a mental health assessment conducted by a qualified mental health professional; (2) development of a mental health needs list; (3) list of child's strengths; and (4) development of a mental health treatment plan.

Health Care Coordination Activities

Before the mental health assessment takes place, you can help further the process by gathering records on the child's past mental health issues, diagnoses, and treatment, if any. After the assessment is completed, you will be involved in supporting the child's mental health treatment plan, including working with the child's caregivers, birth parents, and service providers.

Practitioners providing the assessment may include:

Physicians experienced in providing mental health services:

- Developmental/behavioral pediatricians for children under age 5.
- Child and adolescent psychiatrists or general psychiatrists with experience in the care of children and adolescents.

Licensed clinical psychologists with training and/or experience with emotional problems of children and adolescents.

Nurse practitioners with certification in child and adolescent psychiatry.

Certified psychiatric clinical nurse specialists.

Certified social workers (CSWs) or Masters of Social Work (MSWs) with training and/or experience with the emotional problems of children and adolescents.

Components of Mental Health Assessment

The purpose of the mental health assessment is to obtain a complete picture of the child who has just been placed in foster care and to identify any emotional and behavioral needs, issues, or problems or risk thereof arising from the child's situation. Removal from the home, a history of

[13] 18 NYCRR 441.22(c)(2)(vii).

[14] EPSDT 5123.2A.
[15] 18 NYCRR 441.15.

abuse or neglect, separation from parents and siblings, changing schools, and changing foster homes are examples of stressors.

The practitioner derives this picture by obtaining the child's history, interviewing the child, caregivers, and birth parents and completing the following assessment components. It may take more than one interview to obtain the needed information and arrive at a diagnosis. Children are often traumatized by being removed from their homes and need time to adjust to their new situation.

1. Mental health/psychiatric history – obtained by interviewing the child, family, and caregivers, covering the following information:
   - Identifying information
   - Past psychiatric history
   - Past and current psychiatric medications
   - Identification of individual strengths/assets
   - Identification of individual deficits/liabilities
   - Developmental history
   - School history
   - Family history
   - Social and behavioral history
   - Medical history (including results of initial medical assessment)
   - Drug/alcohol history
   - Trauma and abuse history

2. Mental status examination – accomplished by interviewing the child and examining the child's appearance, behavior, feeling (affect and mood), perception, thinking, and orientation to time, place, and person.

3. Assess the circumstances of placement, family life events, and traumatic events, and observe for signs and symptoms:
   - Risks for suicide, self-mutilating behaviors, and/or violence
   - Substance exposure, misuse, abuse, and addiction
   - Maltreatment, including physical, sexual, emotional abuse and neglect
   - Risk of placement disruption
   - Risky sexual behavior
   - Risk of antisocial behavior

4. If clinically indicated, completion of diagnostic screening and assessment tools (behavior, mood, etc.) *(see section 7, Resources, for a list of assessment tools).*

5. If clinically indicated, psychological testing

6. Development of a mental health needs list or diagnosis *(see Chapter 2, Preventive and Ongoing Health Care, for information on the DSM-IV-TR Manual).*

7. Mental health treatment plan for the child's identified needs, consisting of treatment goals; treatment objectives; and treatment methods/interventions/services (types, frequency, specific providers).

Guidance for Caregivers

You have an important role in helping foster parents or childcare staff understand the mental health needs of the child placed in their care. If mental health information is available at the time of placement, discuss it with the caregivers so that they can be more aware of the child's needs. As the child becomes more comfortable in the placement setting, he or she may begin to exhibit certain different behaviors. This is a critical time to support caregivers and provide practical guidance and training to address these changes. Caregivers should be aware of this possibility, make note of the child's behavior, and pass the information on to the person conducting the mental health assessment. It is important to realize that the child may be reacting to feelings of separation, loss, or rejection, and his or her behavior may be more a reflection of the situation than an indicator of a genuine mental illness.

Some of the behaviors that caregivers should be alert to are:

Angry outbursts.
Excessive sadness and crying.
Withdrawal.
Lying or stealing.
Defiance.
Unusual eating habits, such as hoarding food or loss of appetite.
Sleep disturbances.
Sexual acting out, such as seductive behaviors toward caregivers.
Change in behavior at school, including truancy.

Please note that if the child appears to be in crisis, immediate referral to a mental health provider should be made. If a foster parent identifies a child in crisis, he/she should contact the caseworker immediately.

Informed Consent for Non-Routine Health Care

Even if consent for routine evaluation and treatment has been obtained, medical providers will generally look for a higher level of consent – known as "informed consent" – for non-routine or elective medical or mental health care not generally provided as part of primary health care. Local districts that have obtained consents from a parent or guardian should evaluate the scope of such consent to determine whether it addresses both routine and non-routine medical care and treatment. For procedures or interventions that are not emergency in nature but call for informed consent, the health care provider should always contact the caseworker or the health care coordination staff at the agency. It is then the agency's responsibility to facilitate the consent process.

Informed consent is required for:

Any hospitalization.

Dispensing of any psychiatric medication *(see Chapter 5, Medication Administration and Management).*

Any procedure that requires anesthesia.

Any surgery.

Any invasive diagnostic procedure or treatment.

"Informed consent" implies that the person giving consent has had the opportunity to ask questions, understands the risks, benefits, and alternatives of the treatment, and has been informed of the following types of information:

Diagnosis and symptoms being treated.
How the procedure/therapy fits with the treatment plan.
Nature of the procedure/treatment.
Benefits, risks, and side effects.
Projected course and duration of therapy.
Alternative approaches to treatment.
Assurance of monitoring for complications and side effects.
How to contact the clinical provider of the proposed procedure/treatment.
Location where the procedure/treatment will be performed.
Necessity, type, and risks of anesthesia, if any.
Proposed length of hospitalization, if any.

It is best to give this type of information to the person (birth parent or guardian, adolescent) orally and to be available to answer questions. If requested, follow up the discussion with information in writing.

If the birth parent or guardian objects to signing the consent, take the following steps:

Set up a meeting with the practitioner to educate the parent.
Obtain a second opinion, if requested.
Pursue any reasonable treatment options that the parent may suggest.