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Tufts Medical Center

Examining Concern around Psychotropic Medication Oversight for Children and Adolescents in Foster Care

Common Measures for Population-level Monitoring

Many states employ methods to review trends of psychotropic medication use and potential safety concerns. Data gathered at baseline and over time might allow you to track trends over time on a variety of measures, such as:

- On any psychotropic medication
- On specific classes of medications (e.g., antidepressants, stimulants, mood stabilizers, antianxietals)
- On more than 1 medication from the same class (co-pharmacy)
- On 2, 3, and 4+ psychotropic medications
- **< 6 years old** on any psychotropic medication
- **< 6 years old** on 2, 3, and 4+ psychotropic medications
- **< 6 years old** on antipsychotics

Questions to consider:

1. What would be the advantage(s) and drawback(s) of the various measures described above?

2. From your perspectives, which of these measures would you prioritize? Why?

3. How might you use these measures in efforts to improve the quality of care for children and adolescents in foster care?

4. What might be the unintended consequences of these efforts and how would you measure these?

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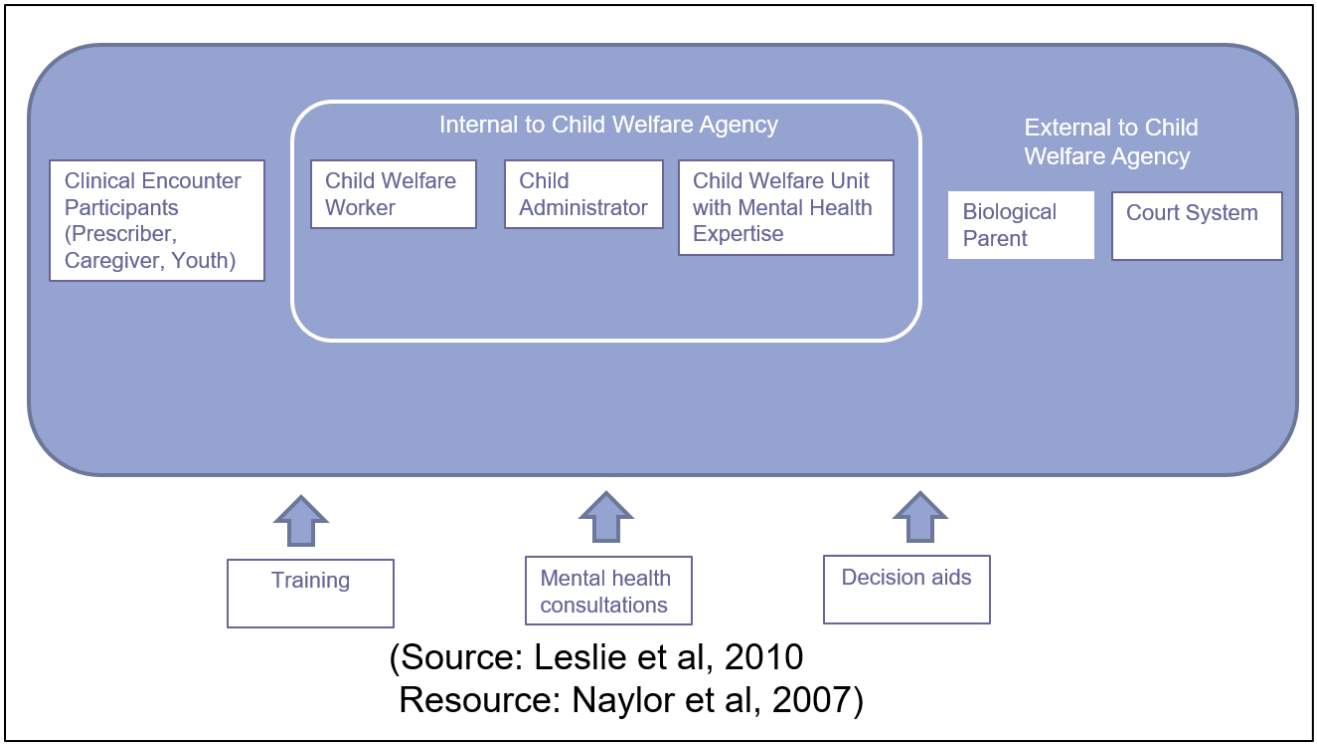
Informed Consent

Child welfare serves in place of the parent (or *in loco parentis),* and is legally responsible to assure for the safety, permanency, and well-being of children who are removed from the home and placed into foster care.

Accordingly, child welfare systems must determine an optimal approach for **informed consent when psychotropic medications are prescribed.** Informed consent can occur close to the clinical encounter and with varying amounts of secondary clinical expertise to inform the decision. See figure below:

Figure 1. Variation in Approach to Informed Consent.[1,2]



(Source: Leslie et al, 2010
Resource: Naylor et al, 2007)

[1] Leslie LK, Mackie TI, Dawson EH, et al. *Multi-state study on psychotropic medication oversight in foster care. Study report and appendix.* Boston, MA: Tufts University Clinical and Translational Science Institute; 2010.
[2] Naylor MW, Davidson CV, Ortega-Piron DJ, Bass A, Gutierrez A, Hall A. Psychotropic medication management for youth in state care: Consent, oversight, and policy considerations. *Child Welfare.* 2007; 86 (5):175.

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Questions to consider:

1. What would be the advantage(s) and drawback(s) of having consent provided at the clinical encounter? By a child welfare unit with mental health expertise? By the current caregiver (e.g., foster parents)? Biological parent? By the court system?

2. How would you configure informed consent for children and youth in foster care? Why?

3. What supports (e.g., training, mental health consultation, decision aids) would you plan to make available? To whom would these be available?

4. What would you measure to determine the intended and potential unintended effects?

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Case Study: Examining Concern around Psychotropic Medication Oversight for Children and Adolescents in Foster Care

Prior Authorization

Prior authorization is increasingly being used both to contain costs and to address safety concerns. Below, you will find points of variation that might characterize the prior authorization process:

1. **Purpose for PA.** Some PAs primarily seek to address cost concerns (e.g., preferred drug lists specifying use of generics before patented medications) while others are established to address safety concerns (e.g., age criteria for antipsychotics prescribed to very young children).
2. **Process for PA.** Some PAs employ an automated review of prescribing while others provide a secondary collegial review by peers.
3. **Exemptions for PA.** Some PAs employ exemptions for particular types of providers (e.g., child and adolescent psychiatrists) while other apply equally to all types of medical care providers.

Some managed care organization contracts prohibit the use of PA for prescribing, others standardize the PA requirements to ensure comparability across insurance systems for Medicaid-insured populations, while others leave it to the discretion of the MCO.

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Questions to consider:

1. What would be the advantage(s) and drawback(s) of using a prior authorization to address safety, quality, and cost?

2. From your perspectives, what would you prioritize in an approach to prior authorization? Why?

3. What reporting requirements, if any, would you require to determine the intended and potential unintended effects of MCO Prior Authorization programs?