RESOLVED, That the American Bar Association urges state, territorial, local and tribal child welfare and juvenile justice agencies to provide adequate resources for assessing and treating emotional and behavioral disorders of children in their custody, including psychosocial and clinical interventions, recreational opportunities and supportive services that can reduce the need for prescribing psychotropic drugs.

FURTHER RESOLVED, That the American Bar Association urges state, territorial, local and tribal child welfare and juvenile justice agencies to develop comprehensive policies, based on best practice guidelines developed in collaboration with medical professional organizations, medical, mental health and disability experts, and other stakeholders designed to facilitate medically appropriate use of psychotropic medications needed by children in the custody of child welfare and juvenile justice systems, while ensuring that medications are not used solely to control behavior.

FURTHER RESOLVED, That the American Bar Association urges state, territorial, local and tribal courts to work with medical professional organizations and other stakeholder groups to develop oversight protocols administered by child and adolescent psychiatrists to ensure that these policies are successfully implemented in child welfare and juvenile justice cases under their jurisdiction, and to ensure that medication regimens are evaluated, and, if appropriate, continue without interruption when placement changes occur or when the child is transitioning out of the foster care or juvenile justice systems.

FURTHER RESOLVED, That the American Bar Association urges attorneys, judges, bar associations, and law school clinical programs on children’s issues to promote education and to develop technical assistance resources on the rights of children in the custody of child welfare and juvenile justice agencies, including legal issues related to appropriate use of psychotropic medication.

FURTHER RESOLVED, That the American Bar Association urges Congress to enact legislation requiring state, territorial, local and tribal governments to report de-identified data, consistent with children’s privacy rights under federal and state law, to appropriate federal agencies on the ongoing use of psychotropic medication for children in foster care and in the juvenile justice system under their jurisdiction.
REPORT

Introduction

Almost every week, a newspaper in some part of this country calls to our attention an upsurge in the number of children and youth who are prescribed psychotropic medications, those substances that are capable of affecting a person’s mind, emotions, and behavior. This increase is reported not just in children in the general population, but in even greater numbers by children and youth who are poor. The highest percentage of use is in children and youth who have been removed from their families and live in foster care, in residential group homes, or in juvenile justice facilities. Investigation into the high rates of use reveals that children in government custody are treated without appropriate medical procedures most parents would insist on and without the court oversight and supervision that these children need. The result is that these children and youth are denied their right to constitutional right to adequate medical care, including the right to avoid the over-administration of psychotropic medications.

Children in foster care and children involved in the juvenile justice system are prescribed psychotropic medications at rates that are termed “alarming.” Foster children are given psychotropic medications at a rate nine times higher than children not in foster care. And, while the data on usage in juvenile justice facilities is much harder to locate, those jurisdictions that gather information are finding that the rate of use is much the same. One report estimates that over fifty percent of the children involved in the juvenile justice system are prescribed psychotropic medications.

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1 Allison Flood, Class of 2015 of the Maurice A. Deane School of Law at Hofstra University, researched and authored this report. The ABA Commission on Youth at Risk is grateful for her important contribution and excellent work.
3 See page 6 herein for a more detailed explanation of psychotropic medication.
7 See Rachel Camp, A Mistreated Epidemic: State and Federal Failure to Adequately Regulate Psychotropic Medications Prescribed to Children in Foster Care, 83 Temp. L. Rev. 369, 373 (2011) (discussing the over-administration of psychotropic drugs to foster children as a nationwide epidemic); see also Camilla L. Lyons et al., Psychotropic Medication Patterns Among Youth in Juvenile Justice, 40 Admin. & Pol’y Mental Health 58, 59 (2013).
psychotropic medications within one month of intake. Pennsylvania reported in October, 2015, that, over a seven-year period, enough antipsychotics were ordered to treat one-third of its youth in juvenile correctional facilities, on average, at any given time.

The reasons for the high level of psychotropic medication use among children who are in foster care or in juvenile justice facilities lie in the trauma, neglect and abuse that these children and youth have suffered. State agencies and court systems avoid investing in a range of psychosocial treatments and therapies to treat children and youth, and instead look to psychotropic medication as a quick solution to the emotional and behavioral disorders these children have and that make them difficult to place in foster care, residential group homes or juvenile facilities. In many cases, these drugs are prescribed without a full medical history, without a diagnosis, with no informed consent, in combination with other psychotropic meds, for off-label use, in amounts greater than the recommended dosage, without monitoring, without utilizing any other treatment alternatives before or during the use of these meds, and as a first resort instead of a last resort.

The American Academy of Pediatrics states that children in care should receive treatment that, if indicated after a full mental health evaluation, incorporates appropriate therapy, including trauma-informed care, with appropriate education and support of the child’s caregivers and caseworkers. Recommended therapies include parent-child interaction therapy, child-parent psychotherapy, trauma-focused cognitive behavioral therapy, and the attachment, self-regulation, and competency model. Unfortunately, not all therapies are widely available, shortages of trained mental health professionals exist and funding is insufficient to ensure that all children can access these interventions. Federal legislation passed in 2014 also requires states to provide normalcy to children in foster care so that a full range of extra-curricular activities, recreation and part-time jobs are available to enhance their overall well-being. Those activities are critical to a child’s development and sense of self-esteem, and also contribute to positive mental health outcomes.

Psychotropic medications can be a useful part of a child’s treatment plan under appropriate circumstances and oversight, and when correct medical protocol is followed. AAP

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9 See Lyons et al., supra note 7, at 59.
13 Id.
14 Preventing Sex Trafficking and Strengthening Families Act (HR 2940, 2014)
recommends that use of these medications should be “diagnosis-specific and evidence-based”, initiated at low doses and altered slowly, with close monitoring for efficacy and adverse effects. No patient should receive therapy with more than one psychotropic medication from any given class.  

Psychotropic medication causes unwanted side effects in children and youth that are not completely known to the medical community. Children report that they feel “like zombies”, unable to function in school and uninterested in outside activities.  Some contemplate suicide, or worse, commit suicide. The short-term effects of over-medication are endless, continue to be studied, and the long-term effects in children and youth are in fact unknown. Short-term complaints range from, but are not limited to, the less severe to the most extreme – anxiety, dizziness, confusion, and changes in behavior, to excessive weight gain, seizures, and even death from liver failure.

A number of organizations weigh in on this issue. The American Academy of Child and Adolescent Psychiatry (“AACAP”) created a Position Statement on the Oversight of Psychotropic Medication Use for Children in State Custody: A Best Principles Guideline, and the National Council of Juvenile and Family Court Judges (“NCJFCJ”) passed a resolution in 2013, both of which are intended to improve the oversight and regulation of psychotropic medication use in the child welfare and juvenile justice systems. The ABA Center on Children and the Law also published a practice and policy brief in 2011 for advocates and judges; the report concluded that children in care are especially vulnerable to the overuse of psychotropic

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10 See, AAP, supra, note 12, citing Texas Department of Family and Protective Services and The University of Texas at Austin College of Pharmacy, Psychotropic medication Utilization Parameters for Children and Youth in Foster Care (Sept. 2013), www.dfps.state.tx.us/documents/Child_Protection/pdf/TxFosterCareParameters-September2013.pdf


19 See Laura K. Leslie et al., Multi-State Study on Psychotropic Medication Oversight in Foster Care, TUFTS CLINICAL & TRANSNATIONAL SCIENCE INST. (Sept. 2010), available at http://www.tuftsctsi.org/~media/Files/CTSI/Library%20Files/Psychotropic%20Medications%20Study%20Report.a shx; see also Barbara J. Burns et al., Effective Treatment for Mental Disorders in Children and Adolescents, 2 CLINICAL CHILD & FAM. PSYCHOL. REV. 199, 213-16 (1999) (discussing that a common side effect of psychotropic medications is sedation); Kristin G. Cloyes, et. al., PRESCRIPTION AND USE OF PSYCHOTROPIC MEDICATIONS IN UTAH DIVISION OF JUVENILE JUSTICE SECURE CARE FACILITIES 4 (2008); AACAP, supra, note 5; Resolution, supra, note 5.
medication and that medication use should be supported with other treatments and therapies to avoid any risk of harm to a child or youth in care.20

This resolution urges states and the agencies that oversee child welfare and juvenile justice systems to develop comprehensive policies consistent with best practice guidelines recommended by AACAP to correct abuses with prescribing psychotropic medication to children.21 The resolution encourages attorneys and judges to increase their awareness of the issues around psychotropic medication use in children and to insure that court oversight processes are implemented as recommended by NCJFCJ to insure that children in both systems receive appropriate treatment for mental health conditions and trauma, and that the treatment continues without interruption when placement changes occur or when children and youth transition out of either or both systems. The resolution further encourages attorney and judges to increase education of the legal issues around psychotropic medication use in children. Finally, the resolution urges Congress to enact legislation that will require states to collect de-identified data, consistent with all children’s privacy rights under federal and state law, and to monitor the use of psychotropic medication for all children in state custody.

I. The Over-Administration of Psychotropic Medications to Children in State Custody is a Nationwide Problem

Psychotropic medications are defined as “substances that act directly on the brain to chemically alter mood, cognition, or behavior.”22 Their effect is typically achieved by altering the process of the brain’s neurotransmission.23 Psychotropic medications are typically divided into six classes: stimulants, antidepressants, depressants, antipsychotics, mood stabilizers, and anxiolytics (anti-anxiety).24

Of all the psychotropic medications, antipsychotics are, by far, the most frequently prescribed medicines to foster children and youth involved in the juvenile justice system.25 Antipsychotics were initially designed to treat schizophrenia and bipolar disorder in adults, but are commonly prescribed to these children to treat behavioral issues for which the FDA has not approved, including agitation, anxiety, acting out, and irritability.26 The most commonly prescribed antipsychotics, which are also among the most powerful medications, include

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20 Solchany, supra note 17.
21 The juvenile justice system is a state system, with the exception of federal jurisdiction over Native American juvenile offenses committed on reservations. In the District of Columbia, juveniles are sent to federally operated facilities as well. For purposes of this resolution, the District should be viewed as a state, and the Bureau of Prisons as a state agency.
23 Id.
26 Abdelmalek et al., supra note 8.
Foster children and youth involved in the juvenile justice system are prescribed psychotropic medications at rates that deserve close scrutiny. At a nation-wide level, studies have shown that up to fifty percent of all children in foster care are prescribed one or more of these psychotropic medications at any given time, a rate nine times higher than children not in foster care. While published national data on the rates of psychotropic medication use in either detained or incarcerated juvenile populations does not currently exist, recent studies conducted in various states indicate that these youth are also prescribed psychotropic medications at rates higher than youth in the general population. A study of the Utah Juvenile Justice System indicated that fifty-six percent of youth involved in the juvenile justice system were prescribed psychotropic medications. A study of the Washington State Juvenile Justice System indicated that thirty-six percent of youth involved in the juvenile justice system were prescribed psychotropic medications. And, a study of the Oregon State Juvenile Justice System indicated that fifty-eight percent of females and thirty-two percent of males involved in the juvenile justice system were prescribed psychotropic medications.

The most commonly prescribed psychotropic medications to foster children and youth involved in the juvenile justice system are antipsychotics. Foster children are given antipsychotics at a rate nine times higher than children not in foster care, according to a 2010 sixteen state analysis by Rutgers University. An estimated fifty percent of youth under eighteen who are within the juvenile justice system are prescribed antipsychotics, compared to just eight to ten percent in the general population. Additionally, a 2007 study of the Florida Department of Juvenile Justice indicated that in twenty-four months, the Department of Juvenile Justice purchased 326,081 tablets of antipsychotic medications for use in state-operated jails –


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27 Id.
28 Id.
29 See Camp, supra note 7, at 373; see also Prescription Psychotropic Drug Use Among Children in Foster Care: Hearing Before the Subcomm. on Income Sec. and Family Support of the H. Comm. on Ways and Means, 110th Cong. 11 (2008), available at http://www.gpo.gov/fdsys/pkg/CHRG-110hhrg45553/html/CHRG-110hhrg45553.htm (citing the testimony of Laurel K. Leslie, M.D., in which she stated that the research studies available show rates of psychotropic drug medication use ranging from 13-50% among children in foster care and the testimony of Tricia Lea, Ph.D., in which she stated that that in 2003, twenty-five percent of children in Tennessee foster care were prescribed psychotropic drugs); Melissa D. Carter, Medicating Trauma: Improving Prescription Oversight of Children in Foster Care, 46 CLEARINGHOUSE REV. 398, 399 (2013).
30 See Lyons et al., supra note 7, at 59; see also Alison Evans Cuellar et al., Incarceration and Psychotropic Drug Use by Youth, 163 PEDIATRIC ADOLESCENT MED. 219 (2008).
31 See Cloyes et al., supra note 7, at 8.
32 See Lyons et al., supra note 7, at 59.
33 Id.
34 Abdelmalek et al., supra note 8.
enough to hand out 446 pills a day, seven days a week, for two years in a row to the 2,300 youth involved in the Florida juvenile justice system.36

Not only are foster children and youth involved in the juvenile justice system prescribed psychotropic medications – the majority of which are antipsychotics – at rates that are disturbing, but they are also heavily over-medicated.37 Polypharmacy, the use of prescribed psychotropic medications concomitantly, or in combination, is common even though medical experts consistently state that children and youth should rarely take multiple psychotropic medications at the same time.38

A recent study of forty-seven states and the District of Columbia indicated that 38.3 percent of states were administering multiple psychotropic medications simultaneously to foster children and 21.3 percent of states were engaging in polypharmacy before monopharmacy.40 Additionally, a recent United States Government Accountability Office (“GAO”) study of 100,000 foster children across five states found that, in Texas, foster children were fifty-three times more likely to be prescribed five or more psychotropic medications at the same time than non-foster care children.41 And, a recent study of the Utah Juvenile Justice system indicated that sixty-two percent of the youth prescribed psychotropic medications were taking more than one medication concomitantly, while thirty-eight percent were only taking one psychotropic medication.42 GAO experts stated, upon review of these findings, that they did not find any evidence supporting the use of five or more psychotropic medications in adults, let alone in children.43

Psychotropic medications have a number of adverse effects on children.44 Side effects include tics, increased heart rate and blood pressure, vomiting, increased appetite and weight gain, sleepiness, sedation, stomachaches, dizziness, diarrhea, tremor, hair loss, unusual bleeding or bruising, rash or hives with itching, and suicidal thoughts and attempts.45 Other side effects include akathisia (motor restlessness, desire to remain in constant motion), acute dystonia (spasms of upper body, face, tongue and eyes), neuroleptic malignant syndrome (rare but potentially fatal, it is characterized by muscular rigidity and altered consciousness), tardive dyskinesia (involuntary movements of various body parts, which can be irreversible), and an

37 See Burton, supra note 22, at 477; see also U.S. Gov’t ACCOUNTABILITY OFFICE, GAO-12-270T, FOSTER CHILDREN: HHS GUIDANCE COULD HELP STATES IMPROVE OVERSIGHT OF PSYCHOTROPIC PRESCRIPTIONS (2011).
38 Melissa D. Carter, Medicating Trauma: Improving Prescription Oversight of Children in Foster Care, 46 CLEARINGHOUSE REV. 398, 399 (2013).
39 Id.
40 Leslie et al., supra note 19. Monopharmacy means the use of a single medication, as opposed to polypharmacy, which is the use of multiple medications. Id.
41 U.S. Gov’t ACCOUNTABILITY OFFICE, supra note 37.
42 See Cloyes et al., supra note 19, at 7-8.
43 U.S. Gov’t ACCOUNTABILITY OFFICE, supra note 37.
44 Norton, supra note 35, at 159; see also Citizens Comm’n on Human Rights Int’l, supra note 18.
45 Norton, supra note 35, at 160.
increased risk of diabetes. In 2004, a Columbia University review of the pediatric trials of commonly prescribed psychotropic medications found that young people who took them often experienced suicidal thoughts or actions. And in 2006, results of an analysis of FDA data showed that at least forty-five children died between 2000 and 2004 from the side effects of psychotropic medications.

Throughout various interviews of many foster children and youth involved in the juvenile justice system, children report anecdotally that they were heavily medicated while in state custody. These children have stated that psychotropic medications make them “feel like zombies.” For example:

- Eleven-year-old Ke’onte from Texas indicated that he was on at least twelve different psychotropic medications while in foster care, up to four of them concomitantly. The medications made him irritable and exhausted, caused a loss of appetite, and put him “in a lights-out mode fifteen minutes” after he had taken them.
- Fourteen-year-old Westley stated that he was prescribed five psychotropic medications concomitantly. He would resist the pills because he did not like the way they made him feel.
- Mark, a former foster child from California, was also prescribed multiple psychotropic medications concomitantly. He stated that he felt too “zoned out” to focus on high school and was so groggy that he was cut from his varsity basketball team.
- Yolanda, a former foster child who was also involved in the California juvenile justice system, indicated that doctors prescribed her a series of powerful psychotropic medications in order to numb her pain from being physically and sexually abused and control her outbursts. She was “so medicated with psychotropic medications that she literally lost her ability to speak.”

Protocols for the administration of psychotropic medications to children in custody are absent. Psychotropic medication to foster children and youth involved in the juvenile justice system are prescribed and administered without the informed consent of the child, his/her parent,
or court-appointed guardian. In the majority of states, the state agency often provides consent on behalf of the child, although sound reasons, discussed below, recommend against this practice. Second, psychotropic medications are prescribed without a full medical history and/or making any diagnostic assessment, without record keeping by the agency who has custody of the child, without protocols to monitor and review medication use on a short or long-term basis, and with inadequate court oversight. Little documentation of the administration of psychotropic medications exists and periodic reviews of a medication plan are lacking. Third, psychotropic medication are requested and prescribed to control behavior, in dosages exceeding the maximum recommendation, and for off-label use. Foster children and youth involved in the juvenile justice system are prescribed these medications simply for the purpose of sedating the child – basically, maintaining control – a practice which has been widely condemned. Last, psychotropic medications are prescribed without any previous or concurrent use of alternate therapies or psychosocial treatments.

II. AACAP and NCJFCJ: Best Principles Guideline and Recommendations to Improve the Administration and Oversight of Psychotropic Medications

As a result of the various problems foster children and youth involved in the juvenile justice system have faced, AACAP and NCJFCJ have instituted guidelines and recommendations to improve use of psychotropic medications for children in the child welfare and juvenile justice system.

1. No psychotropic medication should be prescribed without informed consent by the child, his/her parent, guardian and/or licensed caretaker.

As stated, in many states, the state agency often provides consent for the administration of psychotropic medications on behalf of the child-patient. AACAP has recommended against this practice, particularly because a state agency should not be equated with a parent for the purpose of medicating a child since the state does not form an emotional attachment with the child. While in state custody, the child interacts with a long series of social workers, clinic

58 Id. at 380; see also Joseph V. Penn et al., Practice Parameter for the Assessment and Treatment of Youth in Juvenile Detention and Correctional Facilities, 44 J. AM. ACAD. CHILD ADOLESCENT PSYCHIATRY 1085, 1094-95 (2005).
59 See Camp, supra note 7, at 380; see also Leslie et al., supra note 19 (discussing that a state should not be equated with a parent for the purpose of medicating a child since the state does not form an emotional attachment with the child).
60 See Leslie et al., supra note 19; see also Penn et al., supra note 57, at 1094-95.
61 See U.S. GOV’T ACCOUNTABILITY OFFICE, supra note 37; Leslie et al., supra note 19.
62 See Leslie et al., supra note 19; see also Camp, supra note 7, at 373; Penn et al. supra note 58, at 1094.
63 See Penn et al., supra note 58, at 1095-96.
64 See AACAP, supra note 5 see also Resolution, and supra note 5.
65 See Leslie et al., supra note 19; see also Michael W. Naylor et al., Psychotropic Medication Management for Youth in State Care: Consent, Oversight and Policy Considerations, 86 CHILD WELFARE 175, 182 (2007).
66 See AACAP, supra note 5; see also Leslie et al., supra note 19; Bernard P. Perlmutter & Carolyn S. Salisbury, “Please Let Me Be Heard:” The Right of a Florida Foster Child to Due Process Prior to Being Committed to a Long-Term, Locked Psychiatric Institution, 25 NOVA L. REV. 725, 734 (2001).
doctors, caseworkers, and supervisors making it impossible for anyone in the agency to really know the child. The state is less likely to make sound medical decisions for the child because it is unaware of the intricacies of the child’s medical or behavioral history.

According to the Best Principles Guideline, states should not permit a state agency to consent to the administration of psychotropic medications on behalf of a child. AACAP recommends that states should identify the parties empowered to consent for treatment for youth in state custody in a timely fashion and establish a mechanism to obtain consent for psychotropic medication management from minors when possible. Studies show that older youth possess the developmental capabilities necessary for providing informed consent to personal health and medical treatment, and so child development psychologists and AACAP recommend that children fourteen years of age or older provide informed consent on behalf of themselves. For children under fourteen years of age, informed consent should be obtained by the parent, guardian, or licensed caregiver.

States should obtain and distribute simply written psychoeducational materials and medication information sheets to facilitate the consent process. Both AACAP and NCJFCJ have recommended that these materials consist of information about the proposed medication, and its risks and potential side effects, including adverse effects of sudden discontinuation of psychotropic medications.

2. No psychotropic medication should be prescribed without appropriate administration, oversight, and regulation.

AACAP makes several recommendations to improve the oversight and regulation of psychotropic medication use in foster children and children involved in the juvenile justice system. The Best Practice Guidelines note that both a short-term and long-term monitoring plan is essential for assessing any developments or increases in suicidal ideation, initial side effects, and potential changes over time. The guidelines recommend that states should require the prescriber to reassess the child frequently in order to monitor the response to the treatment

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68 Perlmutter & Salisbury, supra note 67, at 734.
69 Id; see also GARY B. MELTON, ET AL., NO PLACE TO GO: THE CIVIL COMMITMENT OF MINORS 157-58 (1998).
70 AACAP, supra note 5; Resolution, supra note 5.
71 AACAP, supra note 5; Resolution, supra note 5; Penn et al., supra note 57, at 1094-95.
73 AACAP, supra note 5.
74 Id.
75 AACAP, supra note 5; Resolution, supra note 5.
76 Solchany, supra note 17; AACAP, supra note 5; Resolution, supra note 5.
77 See Magellan Health, Appropriate Use of Psychotropic Drugs in Children and Adolescents Magellan Health (2013), available at http://www.magellanprovider.com/MHS/MGL/providing_care/clinical_guidelines/clin_monographs/psychotropicdrugsinkids.pdf; see also Solchany, supra note 17; AACAP, supra note 5; Penn et al., supra note 57, at 1094.
and ensure the medication’s effectiveness. This includes, at a minimum, periodic review of the child every six months.

Many states allow psychotropic medications to be prescribed without a full medical history and diagnostic assessment of children and youth. The Best Practice guidelines recommend that each state require its agencies to maintain an ongoing record of diagnoses, height and weight, allergies, medical history, ongoing medical problem list, psychotropic medications, and adverse medication reactions that are easily available to treating clinicians 24 hours a day.

3. **No psychotropic medication should be prescribed to a child in dosages that exceed recommended use, or for off-label or concomitant use, without secondary review.**

Many states prescribe psychotropic medications to foster children and children involved in the juvenile justice system concomitantly, or in combination. Additionally, these states often prescribe psychotropic medications to manage—not treat—these children. This is referred to using the medication as a “chemical restraint,” since the medication is being used without a therapeutic purpose, but for the sole purpose of sedating and immobilizing the child. Concomitant use and chemical restraint of these children has been widely condemned by the AACAP and the Child Welfare League.

Many states are prescribing psychotropic medications to these children at dosages exceeding current manufacturer, federal, professional and internal state maximum recommendations. An increasing number of studies show that higher dosages increase the potential for adverse side effects, and that for some medications, a higher dose may actually be less effective than the more moderate recommended dose. As a result, the Best Practice Guidelines recommend that psychotropic medications only be administered at therapeutic dosages and should not exceed recommended dosage levels.

4. **Use of alternative therapies must precede or accompany use of psychotropic medications in children and youth in custody.**

In a 2006 report, the FDA approved only thirty-one percent of psychotropic medications for children. Additionally, because pediatric trials of commonly prescribed psychotropic

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79 Magellan Health, *supra* note 77.
80 See Leslie et al., *supra* note 19.
81 **AACAP, supra** note 5.
82 Carter, *supra* note 29, at 399
83 Camp, *supra* note 7, at 378.
84 **See** Burton, *supra* note 22, at 492.
85 *Id.*
86 Leslie et al., *supra* note 19.
87 U.S. Gov’t Accountability Office, *supra* note 37.
89 Cummings, *supra* note 24, at 360.
medications found that children who took them experienced suicidal thoughts or action, the FDA ordered pharmaceutical companies to add a “black box warning” to all commonly prescribed psychotropic medications due to the medications’ effect on children.\textsuperscript{90} A “black box warning” appears on a prescription drug’s label and is designed to call attention to serious or life-threatening risks.\textsuperscript{91} Despite these facts, states prescribe psychotropic medications before exploring alternative treatment options. The Best Practice Guidelines dictate that children should only take psychotropic medications when absolutely necessary and as a last resort.\textsuperscript{92} The guidelines recommend that prior to prescribing psychotropic medications to children or youth, states should consider other methods to treat the child, such as intensive therapy or psychosocial treatments.\textsuperscript{93}

III. States Must Provide Adequate Resources to Improve the Health and Wellbeing of Children and Youth in State Custody and Adopt Comprehensive Policies on Administration and Oversight of Psychotropic Medication

Improved mental health for children and youth who are in foster care or in juvenile justice facilities, including residential care, group homes, residential treatment or secure detention, relies upon much more than decreased use of psychotropic medications. States must provide adequate resources so that care is trauma-informed, and so that timely assessments and treatments for emotional and behavioral disorders of children and youth in custody, including psychosocial and clinical interventions, recreational opportunities and supportive services that can reduce the need for prescribing psychotropic drugs.\textsuperscript{94}

In addition, states and its administrative agencies that oversee child welfare cases and juvenile justice systems, must develop comprehensive policies to protect children in state custody from over-medication. Juvenile and dependency courts should implement administration and oversight protocols in order to manage and regulate psychotropic medication use among children in foster care and youth involved in the juvenile justice system.\textsuperscript{95} Finally, attorneys and judges need to be better educated and assist in providing training to each other and to other stakeholders about the use of psychotropic medication in children.

\textsuperscript{90} See Citizens Comm’n on Human Rights Int’l, supra note 18.
\textsuperscript{92} Leslie et al., supra note 19.
\textsuperscript{93}Solchany, supra note 17; AACAP, supra note 5; Resolution, supra note 5.
\textsuperscript{94}See, Children’s Defense Fund Mental Health Fact Sheet (March 2010), http://www.childrensdefense.org/library/data/mental-health-factsheet.pdf; Oregon Department of Human Services, Tip Sheet Psychotropic Medications Guide for caseworkers and advocates of foster youth, DHS 0130 (April, 2014); see AAP supra note 12.
\textsuperscript{95} Congress’ power to require states to implement psychotropic drug administration and oversight protocols is originated from tying the requirements to federal funding. See The Am. Acad. of Pediatrics, Health and the Fostering Connections Act of 2008, FOSTERINGCONNECTIONS.ORG (Feb. 2013), available at http://www.childrensdefense.org/child-research-data-publications/data/state-data-repository/perspectives-on-fostering.pdf. If Congress tied this legislation to the health care provision of the Fostering Connections Act, states would be incentivized to immediately comply because they would receive federal funding for doing so. Id.; see also Camp, supra note 7, at 395.
Every state across the Unites States should follow AACAP and the National Council of Juvenile and Family Court Judges Best Practice Guidelines and recommendations in order to improve the administration and oversight of psychotropic medication use in their child welfare and juvenile justice systems. There are a number of states that have implemented some of the AACAP and the National Council of Juvenile and Family Court Judges Best Practice Guidelines and recommendations. According to the Tufts Institute’s 2010 analysis of the policies and practices of forty-seven states and the District of Columbia, twenty-six states have some written policy or set of guidelines regarding psychotropic medication use in children in state custody.96 Thirteen states are in the process of developing a guideline, and nine states have no policy or guideline regarding psychotropic medication use.97

Although half of the states have implemented some type of written guidelines regarding psychotropic medication use in state-involved children, these guidelines are seldom comprehensive in their scope.

The Tufts report indicates that, in the twenty-six states that have written policy or guideline regarding psychotropic medication use, only two states included the state-involved child in the informed decision making process.98 These two states acknowledge that states’ informed consent processes need to be strengthened in order to protect youth from being overmedicated.99 Their solution includes the youth in the informed consent process and providing youth with information about the potential medication, its side effects and risks.100 In the other twenty-two states, informed consent authority resides with the child welfare agency, despite the fact that the AACAP has strongly recommended against this practice.101 If parents have not lost their rights to make health care decisions about a child, that parent should have informed consent; if that right is temporarily resting in the jurisdiction of a state agency, then a guardian should be appointed to give informed consent in the best interest of the child.

In thirteen states currently developing policy, all thirteen expressed interest in involving the child, when age-appropriate, in the decision-making process.102 These states recognized the importance of a “child-centered perspective”103 and are working to implement a comprehensive child welfare psychotropic medication oversight system.104 Their system would obtain informed consent from the youth if psychotropic medication is recommended,105 and actively involve the

96 See Leslie et al., supra note 19. “States” refers to either child welfare agencies or state legislation. Id.
97 See Leslie et al., supra note 19.
98 Id.
99 Id.
100 Id.; see also Naylor et al., supra note 66, at 182.
101 Leslie et al., supra note 19; AACAP, supra note 5.
102 Leslie et al., supra note 19 (finding that states wanted to involve youth, when age-appropriate, in decisions about the child and that the name of the medication, dosage, why it’s being prescribed, side effects, and risks should be provided to the child all in language the child can understand).
103 A “child-centered perspective” is all about focusing on a child’s needs and best interests directly from the perspective of the child. See Barbara Bennett Woodhouse, From Property to Personhood: A Child-Centered Perspective on Parents’ Rights, 5 GEO. J. ON FIGHTING POVERTY 313, 318 (1997).
104 Leslie et al., supra note 19.
105 Id.
youth in both initial and ongoing decision-making. Finally, nine states have no written policy or guidelines regarding informed consent in the psychotropic medication administration process.

The Tufts report finds that all of the states with some policy identify “monitoring a youth’s response to psychotropic medication and its side effects” as a major challenge. While these states recognize that this is an important aspect in medication oversight, they do not require periodic reporting and review of the benefits and side effects of medications. Only North Carolina requires a physician to review the psychotropic medication regimen of a state-involved child at least every six months. In the thirteen states that are developing guidelines, all thirteen expressed interest in ensuring that up-to-date oversight programs and records on each child-patient are in place. Nine states had no written policy or guidelines regarding the oversight and regulation of the psychotropic medication administration process.

Fourteen states in the Tufts report that children in custody are given psychotropic medications in dosages exceeding current maximum recommendations. Eight states administer newer, non-FDA approved psychotropic medications over FDA-approved medications. Eighteen states administer three to five psychotropic medications to state-involved children simultaneously, despite the fact that GAO experts stated that they did not find any evidence supporting the use of five psychotropic medications in adults, let alone children. And eight states allowed psychotropic medications to treat Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, or Adjustment Reaction Disorder to state-involved children who did not exhibit symptoms of any of those disorders.

All forty-eight states in the study understand that psychotropic medication plays an important role in addressing mental health problems; however, all express concern that medications are being used to manage problems that might respond as well, or better, to psychosocial treatments.

In the five years since the Tufts Institute report, several states are developing new legislation and policies to curb the overuse of psychotropic medication among these children. California enacted several new laws in October, 2015, after the San Jose Mercury News’

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106 Id.
107 See id.
108 See id; see also Karen de Sa, California Creates First Guidelines for Prescribing Psych Meds to Foster Youth, BAYAREANews (Apr. 11, 2015), http://www.insidebayarea.com/breaking-news/ci_27891659/california-creates-first-guidelines-prescribing-psych-meds-foster (discussing the fact that although states must regularly report on medication use in order to ensure children are being prescribed safely, Washington, Wyoming, New Jersey and Illinois are moving in the right direction by requiring that children prescribed psychotropic medications receive second medical opinions).
109 See Naylor et al., supra note 66, at 185.
110 See Leslie et al., supra note 19.
111 Id.
112 Id.
113 Id.; U.S. GOV’T ACCOUNTABILITY OFFICE, supra note 37.
114 Id.
115 Id.
ongoing investigation, “Drugging Our Kids” found almost 1 in 4 foster teens in that state receive psychotropic medications.116

IV. Data Should be collected in Both Systems to Demonstrate Appropriate Oversight, Monitoring, and Progress117

Published national data on the rates of psychotropic medication use in either detained or incarcerated juvenile populations do not currently exist.118 In the child welfare system, the Administration of Children and Families reports that “research on psychotropic medication use has relied primarily on Medicaid data, which does not permit examination of medication use in relationship to mental health needs and typically does not distinguish children in foster care by type of foster care placement. Children eligible for Medicaid living in foster care may be living formally with kin caregivers, in group homes or residential placements, or in more traditional nonrelative, foster parent homes. These various types of foster care placements may be associated with different rates of psychotropic medication use or various levels of mental health need. Prior research also does not provide estimates of psychotropic medication use among children who remain at home with at least one biological parent after reports of maltreatment, or children living in informal kin caregiver arrangements.”119

The GAO report recommends states improve documentation on the implementation of psychotropic medication policies and practices in the child welfare system, especially to confirm the use of alternative evidence-based therapies.120 In addition, the Annie E. Casey Foundation, in a partnership with the Center for Health Care Strategies, specifically urges that, in order to limit overuse of psychotropic medication for children in foster care, data should be aggregated across systems for a comprehensive picture of use. Data, which often resides in disparate agencies, are needed for several purposes: to determine baseline rates of psychotropic medication use and expense; to identify outlier prescribing patterns; understand the types, number, and quantity of psychotropic medications prescribed; and track quality and cost outcomes. According to CSCG, New Jersey is examining child welfare, Medicaid, and

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116 Karen De Sa, California Foster Care: New Laws Signed to Restrict Psychiatric Drugs, San Jose MercuryNews (Oct. 6, 2015).
117 Congress’ role as administrator of the child welfare system has been in place since 1980. The federal government sets policy, issues regulations, provides financial assistance to the states, and monitors programs. Federal financing of the foster care system is provided by titles IV-B and IV-E of the Social Security Act. In addition, each State spends a portion of its title XX funds for foster care. Foster care children qualifying for coverage under title IV-E also qualify for Medicaid benefits. Congress regularly receives reports on child welfare outcomes based on data that states submit in order to receive funding. In contrast, the federal government’s role in collecting data on juvenile justice indicators is more limited. See, Peter J. Pecora and Mark A. Pecora, Challenges and Opportunities in Foster Care (2008), http://www.americanbar.org/newsletter/publications/gp_solo_magazine_home/gp_solo_magazine_index/fostercare.html; Federal- and State-level Data (2015), http://youth.gov/youth-topics/juvenile-justice/federal-and-state-level-data
118 See Lyons et al., supra note 7, at 59. Children and youth in juvenile justice facilities have a variety of treatment providers – some may be treated by the state, some by Medicaid, and others by county or private insurers.
120 U.S. Gov’t ACCOUNTABILITY OFFICE, supra note 37.
children’s behavioral health data to develop a clear picture of both psychotropic medication use and that of psychosocial interventions. The state is also enhancing its child welfare data information system to capture data on psychotropic medication use.\textsuperscript{121} All data, regardless of its source, must be de-identified to protect the privacy rights of children and youth under federal and state law, and in accordance with best practices.

Collection of data on the use of psychotropic medication and psychosocial treatments and therapies in the juvenile justice system in every state, territorial and tribal government is essential to understanding the areas of improvement that must be addressed. Likewise, uniform and consistent monitoring of data in the child welfare system is necessary in order to create better oversight and implementation of policies to benefit the health and wellbeing of the children in their care.\textsuperscript{122}

V. Attorneys and Judges Need More Education on Psychotropic Medications

A highly-functioning legal system is vitally important for children and youth in state custody. Courts give children protection, ensure due process and ultimately make every decision affecting their lives. State agencies are charged with the duty to act in the best interest of the child. Lawyers who represent children have the specific responsibility to advocate either in the child’s best interest or for the child’s express interest on each and every issue that impacts the child in child welfare and juvenile justice cases. Neither courts nor attorneys in the juvenile system can properly serve children and youth when they do not understand or properly address children’s trauma and their mental health needs.

Judge William G. Jones summarized the role of the courts. “Juvenile courts operate like other courts when deciding whether a child was abused or neglected or committed a delinquent act or a status offense. What is unique about juvenile courts is that they also make extensive use of experts, including CPS caseworkers, juvenile probation officers, psychologists, mental health professionals, physicians, domestic violence specialists, educators, child development specialists, foster parents, relative caretakers, and others. The court utilizes the expertise of these individuals to understand children and their families better, why events occurred that necessitated court intervention, and how to prevent recurrence. Juvenile courts attempt to look beyond individual and family deficits to understand the family and child as a whole. They aim to make well-informed decisions to address needs for housing, childcare, in-home services, domestic violence advocacy, mental health or substance abuse treatment, paternity establishment, child support, educational services, or employment. Also unique to the juvenile court, particularly in CPS


\textsuperscript{122} Marian Wright Edelman, \textit{Child Watch Column: Overmedicating Children In Foster Care}, CHILDREN’S DEFENSE FUND (May 22, 2015), http://www.childrensdefense.org/newsroom/child-watch-columns/child-watch-documents/OvermedicatingChildrenInFosterCare.html (bringing attention to the Administration’s current budget proposal that requests $250 million to reduce the over-reliance on drugs and increase the use of appropriate screening, assessment, and interventions, including better data collection and information sharing by child welfare agencies, Medicaid, and behavioral health services).
cases, are the frequent review of parents and the assessment of agency performance.” Judge Jones also emphasized that the court should also take an active role in educating policymakers and the public about issues affecting the needs of these children and youth. The attorneys who function in the juvenile court likewise must develop competence to navigate this system of experts, to assist the court’s understanding of why events occurred, and advocate for the right decisions to be made on behalf of the child. They too are involved in the process of informing policymakers and the public when the issues around child protection and delinquency necessitate change in order to improve outcomes for children and youth.

Attorneys and judges in both the child welfare and juvenile justice systems have long accepted medications and the amount of medication for the children and youth in their cases as normal, expected, and medically necessary. However, the overuse of psychotropic medication among children and youth in state custody demands that lawyers for children and the courts ask many questions about the child’s diagnosis, recommended treatment and alternatives, and the qualifications of the medical professionals prescribing and administering psychotropic medication. Lawyers for children and youth, as well as the courts that have jurisdiction over the cases, should ask, at a minimum, “Why is this prescribed? Why is this amount necessary? Where can I learn more about this medication and its side effects? What are the possible long term consequences of use of this medication?” Moreover, to ensure continued competence and adherence to best practice standards and the rules of professional responsibility, attorneys and judges should be educated and develop technical knowledge on legal issues relating to psychotropic medications and on the appropriate use of psychotropic medication for children.

### Conclusion

Children in foster care and youth involved in the juvenile justice system are overmedicated with psychotropic medications and under-treated for mental and behavioral health conditions as a result of the absence of meaningful, comprehensive state policies. Children, their parents, guardians or caregivers are not given informed consent before these powerful medications are prescribed. Prescriptions are written without the benefit of a complete medical

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124 Jones, *id.*, at 77.


126 NACC Recommendations for Representation of Children in Abuse and Neglect Cases, NAT’L ASSOC. OF COUNSEL FOR CHILDREN, http://swrtc.nmsu.edu/files/2014/12/NACC-<br> Standards-and-Recommendations.pdf (last visited May 27, 2015) (stating that competence is the foundation of all legal representation. For attorneys who represent children and youth, competence includes knowledge of child development, and of trauma and mental health conditions, and treatment and services available to the child. An attorney must have sufficient knowledge to advocate for all of a child’s needs, including their medical and mental health needs, and the court has an ongoing role to ensure that lawyers are continually trained); see also MODEL CODE OF PROF’L CONDUCT 1.1, 1.14(a) (1983); MODEL CODE OF PROF’L RESPONSIBILITY EC 7-1, EC 7-12, DR 6-10 (1980); AMERICAN BAR ASSOCIATION (1996); STANDARDS FOR PRACTICE FOR LAWYERS WHO REPRESENT CHILDREN IN ABUSE & NEGLECT CASES §§ A-1, B-1, C-1 (1996); STANDARDS RELATING TO COUNSEL FOR PRIVATE PARTIES §§ 1.7, 4.3, 6.4, 9.2, 10.1 (1996); STANDARDS FOR PRACTICE FOR LAWYERS REPRESENTING CHILD WELFARE AGENCIES §§ C-2, D-2 (2004).
history and a diagnostic assessment. Protocols do not exist to monitor the side effects of these medications and to adjust medications on an ongoing basis. Off-label use is widespread, often by medical professionals without sufficient training, dosages often exceed manufacturer recommendations, and concomitant use of multiple psychotropic medications is the norm. There is little oversight in the legal system by the courts or by the advocates who are appointed to represent the best interest of children, and children and youth are rarely given the opportunity to give their opinions about their health care and the medications they are taking. It is easier to prescribe psychotropic medications in lieu of alternate treatments or therapies, when the latter should always be used first or as a concurrent treatment with medication. All states should develop policies incorporating the recommendations set forth in this resolution so that foster children and youth involved in the juvenile justice system have the best opportunity for meaningful, appropriate and comprehensive mental health treatment.

Respectfully submitted,
Vanessa Peterson Williams, Chair
Commission on Youth at Risk
February 2016

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127 See Leslie et al., supra note 19; see also CLOYES ET AL., supra note 19 at 63-68.
GENERAL INFORMATION FORM

Submitting Entity: Commission on Youth at Risk

Submitted By: Vanessa Peterson Williams, Chair, Commission on Youth at Risk

1. Summary of Resolution(s). The resolution urges state child welfare and juvenile justice agencies to develop comprehensive policies and state courts to improve oversight for the administration of psychotropic medications for children in state custody – those children who are in the child welfare and/or juvenile justice systems. The resolution also recommends that attorney and judges become better educated on this subject, and that Congress enact legislation to require data collection from states to learn progress that is made on this subject.

2. Approval by Submitting Entity. This resolution was first approved by the Commission on Youth at Risk by electronic vote on April 30, 2015, and then approved again at its fall meeting on October 23, 2015.

3. Has this or a similar resolution been submitted to the House or Board previously? No similar resolution has been previously submitted.

4. What existing Association policies are relevant to this Resolution and how would they be affected by its adoption?

   These policies are relevant: MODEL CODE OF PROF’L CONDUCT 1.1, 1.14(a) (1983); MODEL CODE OF PROF’L RESPONSIBILITY EC 7-1, EC 7-12, DR 6-10 (1980); AMERICAN BAR ASSOCIATION (1996); STANDARDS FOR PRACTICE FOR LAWYERS WHO REPRESENT CHILDREN IN ABUSE & NEGLECT CASES §§ A-1, B-1, C-1 (1996); STANDARDS RELATING TO COUNSEL FOR PRIVATE PARTIES §§ 1.7, 4.3, 6.4, 9.2, 10.1 (1996); STANDARDS FOR PRACTICE FOR LAWYERS REPRESENTING CHILD WELFARE AGENCIES §§ C-2, D-2 (2004). None of the policies would be adversely affected; rather, the resolution urges conformance with these policies.

5. If this is a late report, what urgency exists which requires action at this meeting of the House? Not applicable.


7. Brief explanation regarding plans for implementation of the policy, if adopted by the House of Delegates. The policy will be distributed to various child welfare and juvenile justice organizations, as well as to state and local bar association sections or committees on children. The policy will also be featured on the Commission on Youth at Risk website, in ABA publications, and in websites and materials of the co-sponsoring and supporting ABA entities.

8. Cost to the Association. (Both direct and indirect costs) No cost to the Association is anticipated.
9. Disclosure of Interest. (If applicable) None

10. Referrals.
Co-Sponsors:
    Commission on Homelessness and Poverty
    Health Law Section
    Section of Science and Technology

Supported by:
    Criminal Justice Section
    Commission on Disability Rights

11. Contact Name and Address Information. (Prior to the meeting. Please include name, address, telephone number and e-mail address)

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12. Contact Name and Address Information. (Who will present the report to the House? Please include name, address, telephone number, cell phone number and e-mail address.)

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EXECUTIVE SUMMARY

1. Summary of the Resolution

The resolution urges state child welfare and juvenile justice agencies to develop comprehensive policies and state courts to improve oversight for the administration of psychotropic medications for children in state custody – those in the child welfare and/or the juvenile justice systems. The resolution also recommends that attorney and judges become better educated on this subject, and that Congress enact legislation to collect unidentified data from states to learn whether progress that is made on this subject.

2. Summary of the Issue that the Resolution Addresses

Children in foster care and youth in the juvenile justice system are a vulnerable population with significant unmet healthcare needs. Across the country, they are being prescribed anti-psychotic medications in percentages exceeding children and youth in the general population, often with insufficient medical justification. These medications are prescribed without medical histories or diagnostic assessments, in dosages exceeding manufacturer recommendations, often in combination with other psychotropic medications, and for off-label use. Little is done to monitor these medications, and no state insure these children or youth, or their parents or caretakers, informed consent. These medications are most often prescribed before any alternate therapies or psychosocial treatments are utilized and to control behavior, not in response to a mental health or behavioral health condition. Many concerns are raised by medical professionals about the short-term side effects of these medications, and little is known about long-term effects of these medications on children and youth.

3. Please Explain How the Proposed Policy Position will address the issue

The sponsor, co-sponsors and supporters hope that this resolution will assist states, courts, attorneys and judges, and the federal government to improve the adequacy and range of treatment for mental health conditions of children who are in state custody so that psychotropic medications are utilized only when medically appropriate. Some states are developing comprehensive policies on this issue, some have developed policies that are piecemeal and incomplete, and others have ignored this issue altogether. Court systems and the attorneys who represent children, youth and parents in these cases are beginning to recognize the importance of improving supervision over this subject, and this proposed policy position is consistent with the resolution passed in July, 2013, by the National Council of Juvenile and Family Court Judges, and with the Position Statement on the Oversight of Psychotropic Medication Use for Children in State Custody: A Best Principles Guideline by the American Academy of Child and Adolescent Psychiatrists. This policy resolution also encourages Congress to enact legislation requiring states to report on the use of psychotropic medications in youth in the juvenile justice system, which is currently absent, and to develop better data on this subject for children in foster care.

4. Summary of Minority Views

None are known.