The Texas child welfare system has made major strides to improve appropriate management of psychotropic medications for youth in foster care. The Texas model of STAR Health and the input of outside stakeholders through groups such as the Permanency Judicial Commission for Children, Youth and Families have resulted in improvements in the way that psychotropic medications are delivered and monitored. However, key to continuously strengthening this system is a strong quality assurance process that builds capacity by not just gauging compliance but actively collecting, analyzing and using system-wide data to inform and enhance policies and practices.

The implementation of the STAR Health system was a tremendous step in developing a strong quality assurance process. STAR monitors medications prescribed through data transfers in the Health Passport with the majority of information collected through Medicaid billing as well as service case management. STAR also regularly runs an algorithm which flags any cases that fall outside of the psychotropic medication utilization parameters and is responsible for the Psychotropic Medication Utilization Review (PMUR) process. However, there are children who do not qualify for STAR Health and whose psychotropic medication usage are not monitored in this system. These include children who are placed in Texas through an Interstate Compact on the Placement of Children (ICPC) as well as children who are dual eligible for Medicaid and Medicare. Children placed in Texas through an ICPC, 551 in FY 2011, remain under the jurisdiction of the sending state that is responsible for the financial support of the child as well as final determinations regarding their care. However, the receiving state supervises the child's care and provides eligible children with Medicaid coverage. Therefore, it seems reasonable that children placed in Texas through an ICPC would qualify for membership in STAR Health so that appropriate monitoring of their psychotropic medication usage could take place. The use of a monthly algorithm and case management engagement through STAR Health help to ensure that psychotropic medications are being properly administered. Given that the Government Accountability Office
rated the Texas system as ideal in terms of having an oversight program that monitors usage and adverse reactions, this system should cover all children in custody, including those placed through an ICPC.

Children who are dual eligible for Medicaid and Medicare, 25 in fiscal year 2011, are another population for which accountability for psychotropic medication usage is unclear. Children become dual eligible when they qualify for Social Security Disability Income (SSDI) upon or after entering the foster care system. Although Medicare does some cost sharing in this arena there does not appear to be a monitoring system, such as STAR Health, in place for children receiving Medicare. Given the complex and often severe health needs amongst this population it seems that it would be essential to closely monitor psychotropic medication use in this population.

Although membership in STAR Health includes many benefits, the two that are essential to every child in foster care are the case management services that involve monthly contact with children in care to ensure that they are receiving appropriate health and mental health services and monitoring through an algorithm that draws data from the Health Passport. These are essential tools in ensuring that children are not being inappropriately prescribed psychotropic medications and are having their behavioral and physical health needs met. If children who are placed in Texas through an ICPC and those who are dual eligible are not afforded the same protections under this system then not all children in foster care are covered by STAR Health and there is the potential for children to fall through the cracks.

Outside of the processes in place with STAR Health there are additional safe guards ensuring children and youth in foster care receive proper psychiatric treatment. One such safe guard is requiring that a physician evaluate the continuance of medication on a quarterly basis. However, the Texas Administrative Code explicitly states that the health care professional does not have to see the child in person if he/she determines that an evaluation of the appropriateness of continuing the medication can be made over the phone. The assumption here is that the health care professional would be able to obtain the necessary information over the phone from the foster parent, case worker or other appropriate party. This depends heavily on the observation skills and involvement of foster parents and state workers who may not have the time or adequate training to convey important details to a doctor. The American Academy of Child and Adolescent Psychiatry indicates
best practice as monitoring visits that occur regularly\(^2\). Although allow for flexibility between in person and phone contact this is done under the assumption that appropriate monitoring is occurring at home\(^3\).

To adequately document the effectiveness of the medication as well as potential side effects to the child’s behavior, a minimum of one in person visit every 90 days should be instituted as policy. There are no specific licensing standards on record for primary care physicians or psychiatrists related to in-person visits with children who have been prescribed psychotropic medications. Some facilities/placing agencies already have visitation standards in place, such as Catholic Charities and DePelchin Children’s Center in Houston. However, standards vary across state contracted facilities and placing agencies and not all judges are aware that children are not required to be seen by their prescribing physician. Therefore, a state standard that would not interfere with higher standards agencies already have in place or more frequent visits a physician might require, would serve as a safety net for children in foster care and on psychotropic medications. To ensure that this strategy was effective, DFPS would also need to require that the individual in most frequent contact with the child attends the doctor visit with the child in order to provide the most accurate reporting of medication symptoms.

Reviews of outcomes such as those that take place during a doctor visit serve to ensure in part that a child has been prescribed the appropriate medication based on their behavior. Although there are many medication side effects, many of which are relatively harmless, some include children drooling, unable to focus, and having hand tremors. There are some safeguards in place such as inclusion of the warnings and precautions for each drug based on FDA and other clinical information in the Psychotropic Medication Utilization Parameters for Foster Children. In addition, foster parents and others are provided training about psychotropic medications to ensure a certain level of awareness about their use and impact. However, the quality of children’s placements varies and it is possible that if a concerning behavior is replaced, through the use of medication, with what is perceived by the caregiver as relatively mild side effects, caregivers may not feel compelled to report this information despite the fact that the side effects could have a negative impact on the child’s ability to function in school and in their social environment. Side effects would be less likely to go unnoticed if a physician were required to regularly see the child to which they were prescribing medications. Regular reporting of symptoms would also allow the Health and Human Services Commission (HHSC) to collect and monitor this information, which is not currently procedure.


Procedures regarding data collection, the PMUR process and other aspects of monitoring psychotropic medication use of children in foster care are contained in various places including the web pages of STAR and DFPS. There is, however, very little collected in the DFPS Handbook except for an indication that a physician must evaluate the continuance of medication on a quarterly basis and this evaluation must be documented. The Texas Administrative Code (TAC), a compilation of all state agency rules in Texas, includes this same information in addition to three other pieces of information from licensing: the need for target symptoms and treatment goals to be considered, documentation regarding the need for continuance of medication, and a limit of 180 days for documentation of effectiveness of medication. There appears to be nothing in the Texas Administrative Code that documents the PMUR process, steps a caseworker should take to ensure placements are complying with regulations, or the process by which the use of psychotropic medication by all children in foster care is monitored. In order to ensure transparency in the system it is important that the various working parts of the monitoring process are documented in the DFPS Handbook.

Although psychotropic medications are appropriate in many cases, they should not be the sole tool used to modify behavior and help a child/youth achieve stability. Evidenced based therapeutic interventions, such as Cognitive Behavioral Therapy, assist children and youth in obtaining skills necessary to appropriately interact with their peers and guardians and work through trauma they have experienced. The general principles of the Psychotropic Medication Utilization Review Parameters for Foster Children (2010) even states that unless it would jeopardize the safety of the child or their caretakers, “the role of non-pharmacological interventions should be considered before beginning a psychotropic medication.” However, the number of sessions, and/or extent and quality of a non-pharmacological intervention is not included in the parameters. This should be rectified given that accountability for concurrent use of psychotherapy and counseling is important to ensuring successful behavioral health outcomes for youth.

The child welfare system is full of dedicated individuals striving every day to address the safety and well being of the children in its care. Texas has made great strides in building a better system for youth in foster care who are on psychotropic medications; however, recognizing this success should not impede acknowledgement of gaps in accountability that still exist. Therefore, it is essential that DFPS and its partners such as STAR Health and HHSC:

- Require that utilization of psychotropic medications of all children in the custody and supervision of the Department of Family and Protective Services (DFPS) be appropriately monitored by DFPS and the organizations with which it contracts for medical and behavioral health services. This includes children who are dual eligible for Medicare/Medicaid and those that are under the supervision of DFPS through an Interstate Compact Placement Commission (ICPC). Monitoring activities shall include, but not be
limited to, inclusion in automated pharmacy claims screenings and eligibility for the Psychotropic Medication Utilization Review process.

- Require all prescribing physicians who treat children in foster care to, at a minimum, see these children in person on a quarterly basis to appropriately monitor side effects and impact of psychotropic medications.

- Record reported side effects from physicians in the HHSC data base.

- Include all protocols, including the PMUR process, in the DFPS/CPS handbooks to ensure that all procedures regarding psychotropic meds are clearly outlined.

- Require that non-pharmacological interventions be utilized before beginning a psychotropic medication except in urgent situations where the child is an immediate danger to themselves or others

- Amend the current Psychotropic Medication Utilization Parameters for Foster Children to include criteria related to non-pharmacological interventions such as counseling or psychotherapy.

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One Voice Texas is a network of more than 100 public, private and non-profit organizations and individuals working together to ensure that the health and human services needs of all Texans are addressed in legislative, regulatory, funding and other public policy initiatives.