



January 2017

FOSTER CARE

HHS Has Taken Steps to Support States' Oversight of Psychotropic Medications, but Additional Assistance Could Further Collaboration

GAO Highlights

Highlights of [GAO-17-129](#), a report to congressional requesters

Why GAO Did This Study

GAO previously reported that children in foster care in five selected states were prescribed psychotropic medications at higher rates than other children on Medicaid. GAO also reported that some prescriptions were not supported by research and could pose health risks. GAO was asked to study efforts to oversee psychotropic medications for children in foster care since GAO last reported on the issue in 2014.

GAO examined (1) how child welfare and Medicaid agencies in selected states ensure the appropriate use of psychotropic medications for children in foster care, (2) what is known about the results of their efforts, and (3) the extent to which HHS helps states support appropriate medication use. GAO reviewed relevant federal laws, regulations, and guidance; visited a nongeneralizable group of seven states and five counties in two of those states, selected by foster care population and diversity of location; analyzed selected states' data on medication use in foster care populations; and interviewed officials from federal, state, and county child welfare, Medicaid, and other agencies, as well as officials from nine relevant national organizations selected to represent a variety of views.

What GAO Recommends

GAO recommends that HHS consider cost-effective ways to convene state child welfare, Medicaid, and other stakeholders to promote collaboration and information sharing on psychotropic medication oversight. HHS agreed with GAO's recommendation and provided technical comments.

View [GAO-17-129](#). For more information, contact Kay E. Brown at (202) 512-7215 or brownke@gao.gov.

January 2017

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HHS Has Taken Steps to Support States' Oversight of Psychotropic Medications, but Additional Assistance Could Further Collaboration

What GAO Found

State child welfare and Medicaid officials in seven selected states reported a variety of practices to support the appropriate use of psychotropic medications, which affect mood, thought, or behavior, for children in foster care. Practices include screening for mental health conditions, developing prescription guidelines, and monitoring a child's health while on medication. Additional state efforts aim to increase mental health knowledge among stakeholders and improve access to mental health services. However, officials in four selected states and from five national mental health organizations said limited access to mental health services was a challenge. Five of the selected states have begun offering remote consultation services that connect patients with mental health specialists. State officials said strong interagency collaboration and outreach to stakeholders helped them implement practices more effectively.

While some selected states have reduced medication use among these children, states focused on other measures to gauge the results of their efforts. Four of the seven selected states reduced medication use from 2011 through 2015, two states had steady rates, and the remaining state did not have data during this time period. These data, however, cannot be compared across states because states use different methodologies to collect data. Officials in three selected states said reducing medication use may not be appropriate for every child, and officials in all seven states said they focus instead on measures such as tracking the use of medications that can have negative side effects and the use of psychosocial services (e.g., therapy) for children in foster care. Officials in most selected states discussed limitations with gathering data needed to oversee medication use, such as disparate data systems, resource constraints, and privacy concerns related to data sharing among state child welfare and Medicaid agencies and with managed care organizations. Officials in some states that shared data said they overcame privacy concerns through written interagency agreements and educating stakeholders.

The Department of Health and Human Services (HHS) has taken steps to help state child welfare and Medicaid agencies support the appropriate use of psychotropic medications and identify mental health needs and treatments for children in foster care. HHS has focused its efforts on practices for prescribing, screening and diagnosis, and access to trauma-related services. HHS is also working with states to implement voluntary measures to track medication use, other mental health treatments, and a child's overall health. In 2012, HHS hosted a meeting for state leaders to help them establish effective medication oversight practices. Despite the positive outcomes resulting from this meeting, and HHS guidance that says an agency goal is to facilitate cross-system collaborations, such as in the oversight of psychotropic medications, it has not convened meetings with all stakeholders together since 2012. Though HHS has conducted webinars, created learning communities, and convened smaller meetings, HHS officials said it has no plans to convene all stakeholders as it did in 2012 due to resource constraints. Officials in three selected states said more federal support to bring together state stakeholders could help address ongoing issues, such as privacy concerns around data sharing.

Contents

Letter		1
	Background	5
	Selected States Have Practices to Support the Prescribing Process and Educate Stakeholders on the Appropriate Use of Psychotropic Medications	14
	While Some Selected States Reduced the Use of Psychotropic Medications, They All Focused on Other Measures to Gauge the Results of Their Efforts	25
	HHS Assists States in Addressing Medication Use and the Mental Health Needs of Children, Though More Could Be Done to Support Collaboration across State Agencies	33
	Conclusions	44
	Recommendation for Executive Action	45
	Agency Comments and Our Evaluation	45
Appendix I	Objectives, Scope, and Methodology	47
Appendix II	Selected State Information	51
Appendix III	Agency Comments from the Department of Health and Human Services	58
Appendix IV	Staff Acknowledgments	61
Related GAO Products		62
Figures		
	Figure 1: Examples of Stakeholders That May Be Involved in Ensuring Appropriate Mental Health Treatments for Children in Foster Care	9
	Figure 2: Activities for Physicians in Prescribing Psychotropic Medications to Children	12

Figure 3: Selected States' Practices to Assess Children's Mental Health Needs	16
Figure 4: Selected States' Practices to Support Appropriate Treatments for Children	17
Figure 5: Selected States' Practices to Seek Agreement on a Child's Prescription	19
Figure 6: Selected States' Practices for Ongoing Oversight of a Child's Prescriptions	20
Figure 7: Selected States' Practices to Increase Stakeholders' Mental Health Knowledge and Access to Mental Health Services for Children	21

Abbreviations

AACAP	American Academy of Child & Adolescent Psychiatry
ACF	Administration for Children and Families
ADHD	attention deficit hyperactivity disorder
CMS	Centers for Medicare & Medicaid Services
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	Department of Health and Human Services
SAMHSA	Substance Abuse and Mental Health Services Administration

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January 5, 2017

The Honorable Orrin Hatch
United States Senate

The Honorable Ron Wyden
United States Senate

The Honorable Tom Carper
United States Senate

The Honorable Claire McCaskill
United States Senate

Multiple studies have shown that children in foster care may have more mental health conditions than those in the general population,¹ and prior GAO reports have looked at the rate at which these children are prescribed psychotropic medications, which affect mood, thought, or behavior.² While information on the number of children in foster care on psychotropic medications nationwide is limited, in our prior work we found that these children in five selected states were prescribed psychotropic medications at rates 2.7 to 4.5 times higher than other children on

¹See, for example, H. Ringeisen, C. Casanueva, K. Smith, and M. Dolan, *National Survey of Child and Adolescent Well-Being II Baseline Report: Children's Services*, OPRE Report #2011-27f (Washington, D.C.: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, November 2011) and D. Johnson and M. R. Gunnar, "Growth Failure in Institutionalized Children," *Monographs of the Society for Research in Child Development*, vol. 76, no. 4 (2011).

²See, for example, GAO, *Foster Children: HHS Guidance Could Help States Improve Oversight of Psychotropic Prescriptions*, [GAO-12-201](#) (Washington, D.C.: Dec. 14, 2011), *Children's Mental Health: Concerns Remain about Appropriate Services for Children in Medicaid and Foster Care*, [GAO-13-15](#) (Washington, D.C.: Dec. 10, 2012), and *Foster Children: Additional Federal Guidance Could Help States Better Plan for Oversight of Psychotropic Medications Administered by Managed-Care Organizations*, [GAO-14-362](#) (Washington, D.C.: April 28, 2014). Also see related GAO products listed at the end of this report.

Medicaid in 2008.³ As part of that review, we also reported on the prevalence of certain prescribing patterns not supported by research that could pose health risks. These patterns included the use of five or more psychotropic medications at the same time, doses exceeding maximum levels based on labels approved by the Food and Drug Administration, and prescriptions made to children under the age of 1.

There are a number of state and federal agencies that play a role in ensuring that children in foster care receive appropriate treatments for mental health conditions. At the state level, child welfare and Medicaid agencies, along with other partners, have various responsibilities that help ensure appropriate treatments for children in foster care.⁴ State child welfare agencies are primarily involved in determining where and with whom a child in foster care should live (placement) and for providing or arranging needed supports, including certain physical and mental health services. In addition, most children in foster care are eligible for Medicaid, and state Medicaid agencies may choose from a variety of delivery systems to provide and pay for their health services.⁵ At the federal level, the Department of Health and Human Services (HHS) monitors state implementation of relevant federal programs, including those that provide federal assistance to support state child welfare and foster care

³[GAO-12-201](#). Determining the number of children in foster care on psychotropic medications nationwide is difficult, in part, because the Medicaid Statistical Information System—used to collect key eligibility, enrollment, program, utilization, and expenditure data for the Medicaid program from states—may not reliably identify information specifically for children in foster care. In the report cited above, we identified psychotropic medication claims for children in foster care and on Medicaid by requesting and matching Medicaid and foster care data in the states selected for review.

⁴Several states provide child welfare and Medicaid services under county- rather than state-administered agencies. While this report focuses on states, the District of Columbia, certain U.S. territories, and Indian tribal organizations may also participate in federal programs that support child welfare and foster care programs, as well as Medicaid.

⁵Medicaid is a joint federal-state program that pays for covered health care services, including prescription medications, for eligible low-income individuals. See 42 U.S.C. § 1396 *et seq.* Certain children in foster care are categorically eligible for Medicaid, such as those receiving foster care maintenance payments under title IV-E of the Social Security Act. States are required to provide Medicaid coverage to such children. Children in foster care who are not eligible under this category may qualify for Medicaid under optional eligibility criteria established by a particular state. According to the Congressional Research Service, nearly all children who are in foster care are eligible for health care services funded via Medicaid. In addition, some children in foster care may be eligible for the State Children's Health Insurance Program, a federal-state program that provides health care coverage to children living in families whose incomes exceed the eligibility requirements for Medicaid. However, we focus only on Medicaid in this report.

programs, through the Administration for Children and Families (ACF). HHS also oversees the Medicaid program through the Centers for Medicare & Medicaid Services (CMS), in accordance with federal laws, regulations, and guidance. These agencies, along with HHS's Substance Abuse and Mental Health Services Administration (SAMHSA)—which undertakes efforts to improve substance abuse and mental health treatment, prevention, and related services for individuals—provide support to states in their efforts to ensure child well-being.

You asked us to study efforts to oversee psychotropic medications for children in foster care since we last reported on the issue in 2014. This report examines:

1. how child welfare and Medicaid agencies in selected states work to ensure the appropriate use of psychotropic medications for children in foster care;
2. what is known in selected states about the results of their efforts to ensure the appropriate use of psychotropic medications for these children; and
3. the extent to which HHS helps states support the appropriate use of psychotropic medications for children in foster care.

To address all objectives, we conducted in-person and telephone interviews with officials in seven selected states, including those from child welfare and Medicaid agencies, and with nine national professional and research organizations selected to represent a variety of views on child welfare, Medicaid, and mental health-related policy and research. The states we selected were Arizona, California, Illinois, Maryland, New Jersey, Ohio, and Washington. Our selection criteria included (1) a high percentage of children in foster care in the state when compared

nationwide in fiscal year 2014;⁶ (2) variation in Medicaid⁷ and child welfare systems;⁸ (3) recommendations from national organizations; and (4) geographic diversity. In the two selected states with county-administered child welfare systems, California and Ohio, we selected five counties and conducted interviews with officials from the respective county-level child welfare and Medicaid agencies, as appropriate.⁹ These counties were selected based on factors similar to those mentioned above as well as variation in population density (i.e., rural versus urban). We also conducted a review of selected literature related to the use of psychotropic medications among children in foster care.

To examine how state child welfare and Medicaid agencies work to ensure the appropriate use of psychotropic medications, we also reviewed guidance and other documents identified by officials from selected states and counties. While we identified selected states' oversight practices related to psychotropic medications based on interviews and these document reviews, we did not assess states'

⁶We paid particular attention to states that placed a high percentage of their children in foster care in congregate care, which provides structured 24-hour care in a group setting. For example, residential treatment centers are inpatient facilities other than a hospital that provide specialized services to children, such as psychiatric services. We included these data as part of our selection criteria because HHS previously reported that children placed in group homes or residential treatment centers had higher rates of psychotropic medication use than children in other placements, which may be related to these children having higher rates of potential mental health need. See L.F. Stambaugh et al., *Psychotropic Medication Use by Children in Child Welfare*, OPRE Report #2012-33 (Washington, D.C.: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, 2012) and H. Ringeisen et al., OPRE Report #2011-27f. For the purposes of our report, references to "children in foster care" include those placed in congregate care as well as in other types of settings.

⁷Of our seven selected states, three states—Illinois, Maryland, and Ohio—use a fee-for-service system to deliver psychotropic medications and mental health services to children in foster care on Medicaid. Of the remaining four states, Arizona uses multiple managed care organizations to deliver these services, California may deliver these services under fee-for-service or managed care depending on the county, New Jersey uses multiple organizations to deliver psychotropic medications and a fee-for-service system for other mental health services, and Washington transitioned the delivery of these services from a fee-for-service system to a single managed care organization as of April 1, 2016.

⁸Of our seven selected states, five states have state-administered child welfare systems (Arizona, Illinois, Maryland, New Jersey, and Washington) and two have county-administered systems (California and Ohio).

⁹The counties selected include Fairfield, Lucas, and Perry counties in Ohio, and Los Angeles and Sonoma counties in California.

implementation of specific practices. In addition, while we focused our review on children in foster care, state oversight practices may also pertain to other children on Medicaid. To examine the results of state efforts to ensure the appropriate use of psychotropic medications, we gathered and analyzed available data from selected states on the use of these medications among children in foster care from 2011 through 2015.¹⁰ We determined these data were sufficiently reliable for the purposes of describing trends in the percentage of children in foster care on psychotropic medications for each of the selected states. However, because these states use different methodologies to collect data, the data are not comparable among them. In addition, the results of our analyses are not generalizable nationwide. To examine HHS's actions to support state efforts related to psychotropic medications, we interviewed officials from ACF, CMS, and SAMHSA, and we reviewed relevant documents. We also examined applicable federal laws, regulations, and guidance. For additional information on our scope and methodology, see appendix I.

We conducted this performance audit from September 2015 to January 2017 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Administration of Child Welfare and Medicaid Programs

Children enter foster care when they have been removed from their parents or guardians for reasons such as abuse or neglect, and placed under the responsibility of a state child welfare agency. The agency generally places the child in the home of a relative, with unrelated foster parents, or in a group home or residential treatment center, depending on the child's needs. Child welfare caseworkers at the agency are typically responsible for coordinating placement and needed support services for these children, including those for mental health. If a child is determined to be in need of mental health services, the caseworker is generally

¹⁰We analyzed data for six of our seven selected states. The remaining state—Ohio—was unable to provide data from 2011 through 2015. Ohio child welfare officials said they did not collect data on the use of medications in the past, but began to do so as of May 2016.

responsible for arranging such services to be provided by primary care physicians, child psychiatrists, or other mental health providers.¹¹ State courts, typically juvenile or family courts, are also frequently involved in decisions regarding a child's removal, placement, and services.

Most children in foster care are eligible for Medicaid, and those enrolled may receive physical and mental health services through a variety of service delivery and provider payment systems, such as fee-for-service and managed care.¹² In the traditional fee-for-service delivery system, the state Medicaid agency manages the program and reimburses physicians directly and on a retrospective basis for each health service delivered. Under a managed care model, states contract with one or more managed care organizations and prospectively pay the organizations a fixed monthly fee per patient to provide or arrange for defined health services, which may include mental health services and prescription medications. These organizations, in turn, pay physicians.

States are primarily responsible for administering their child welfare and foster care programs, consistent with applicable federal laws and regulations, which include some requirements that relate to ensuring the well-being of children served by these programs. For example, title IV-E of the Social Security Act authorizes federal funding to states to help cover the costs of operating their foster care and certain other programs.¹³ In addition, title IV-B of the Social Security Act authorizes federal funds to support state child welfare programs and services.¹⁴ Both of these programs establish various requirements that participating states must comply with in order to receive the federal funding. The Fostering Connections to Success and Increasing Adoptions Act of 2008 amended title IV-B to add a requirement that states develop a plan for the ongoing

¹¹For the purposes of our report, we refer to providers who are able to prescribe psychotropic medications and provide mental health services as "physicians." These providers may be primary care physicians, pediatricians, psychiatrists, or other kinds of providers.

¹²Some states may use various combinations of fee-for-service and managed care systems for different types of health services and populations. For example, a state may provide mental health services, such as therapy for children in foster care, under a fee-for-service system, but use a managed care system to provide prescription drug coverage to this population.

¹³Title IV-E is codified at 42 U.S.C. §§ 670-679c. Among other things, title IV-E provides federal financial support to states for the care of eligible children in foster care.

¹⁴Title IV-B is codified at 42 U.S.C. §§ 621-629m.

oversight and coordination of health care services for children in foster care, including mental health and oversight of prescription medications.¹⁵ The Child and Family Services Improvement and Innovation Act amended this provision to require that these plans include protocols for the appropriate use and monitoring of psychotropic medications.¹⁶ HHS's ACF is responsible for monitoring state implementation of title IV-E and IV-B programs. For example, ACF conducts reviews of state child welfare and foster care programs every 5 years to ensure conformity with requirements under these federal programs.¹⁷ ACF also monitors state compliance with title IV-B plan requirements, including the health care oversight and coordination plan, through its review of states' five-year Child and Family Services Plans and Annual Progress and Services Reports.¹⁸ In addition, ACF's mission is to promote the economic and social well-being of families, children, individuals, and communities through funding, guidance, training, and technical assistance.

Under the Medicaid program, states are required to provide eligible children under age 21 with coverage for certain health services, which may include mental health services, through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit.¹⁹ Specifically,

¹⁵Pub. L. No. 110-351, § 205, 122 Stat. 3949, 3961-62. Specifically, the act required that states develop, in coordination and collaboration with certain state agencies, including the state Medicaid agency, and in consultation with pediatricians, other experts in health care, and experts in and recipients of child welfare services, "a plan for the ongoing oversight and coordination of health care services for any child in a foster care placement, which shall ensure a coordinated strategy to identify and respond to the health care needs of children in foster care placements, including mental health and dental health needs." The act further specified that the plan shall include, among several other required elements, an outline of the oversight of prescription medicines.

¹⁶Pub. L. No. 112-34, § 101(b)(2), 125 Stat. 369 (2011) (codified at 42 U.S.C. § 622(b)(15)).

¹⁷ACF's periodic assessments are known as Child and Family Services Reviews. They involve case file reviews and stakeholder interviews, and are structured to help states identify strengths and areas needing improvement within their agencies and programs. States found not to be in substantial conformity with federal requirements must develop a program improvement plan and undergo a review every 2 years instead of 5 years. See 45 C.F.R. §§ 1355.31-1355.37. ACF has conducted two rounds of reviews to date. The third round, which should have started in 2012, was delayed because ACF was revising the instrument used to assess states. ACF reported that the third round of reviews began in 2015 and is expected to be completed in 2018.

¹⁸See 45 C.F.R. §§ 1357.15-1357.16.

¹⁹See 42 U.S.C. §§ 1396a(a)(43), 1396d(a)(4)(B) and (r).

federal law requires coverage of periodic screening services, including a comprehensive health and developmental history of both physical and mental health development, a comprehensive physical exam, appropriate immunizations, laboratory tests, and health education. The EPSDT benefit also covers treatment services necessary to correct or ameliorate any identified physical or mental illnesses or conditions. HHS's CMS oversees state Medicaid programs and provides federal matching funds for eligible services. On an annual basis, states are required to report to CMS information on their Drug Utilization Review programs, including prescribing patterns, cost savings generated by the programs, an assessment of the programs' impact on quality of care, and program operations, including information on new innovative practices adopted by states.²⁰ CMS includes these reports on its website.²¹

In addition, state mental health agencies are generally responsible for planning and operating state mental health systems, and play an important role in administering, funding, and providing treatments.²² These agencies may manage mental health-related federal grants and may work with other state agencies—such as state Medicaid agencies—to identify and treat mental health conditions. They may also contract directly with physicians to deliver treatments or may contract with county or city governments responsible for the delivery of treatments within their local areas. HHS's SAMHSA engages in activities intended to help improve the behavioral health of children in foster care. Such efforts include grants that support the development of community-based services

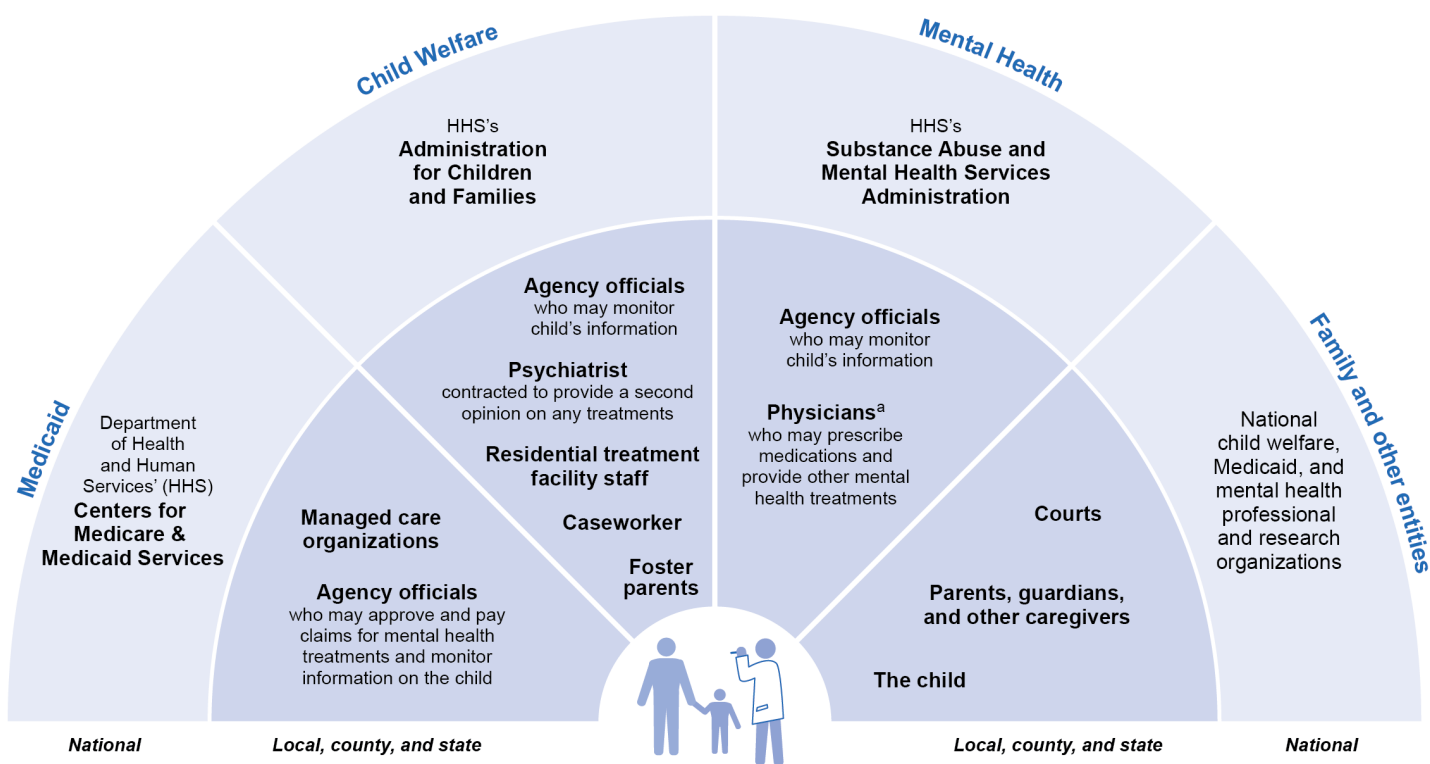
²⁰The Medicaid statute and regulations require states to establish Drug Use Review programs (commonly referred to as Drug Utilization Review programs), which are to include a prospective drug review (screening before prescriptions are filled to identify potential problems, such as duplication of drug therapies, incorrect dosages, and clinical misuse or abuse); a retrospective drug use review (an examination of claims data that is to occur at least quarterly, to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care); and an ongoing educational outreach program to educate practitioners on common drug therapy problems with the aim of improving prescribing and dispensing practices. 42 U.S.C. § 1396r-8(g); 42 C.F.R. §§ 456.700-456.725. These reviews are required only for claims made under fee-for-service systems, although managed care organizations providing drug coverage will be required to conduct such reviews beginning in 2017. 81 Fed. Reg. 27,498, 27,857 (May 6, 2016) (to be codified at 42 C.F.R. § 438.3(s)(4)).

²¹See <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/prescription-drugs/drug-utilization-review.html>.

²²State mental health agencies can be referred to as “behavioral health agencies.” These agencies may also be involved in efforts related to substance abuse and other behavioral health conditions.

for children with mental health conditions and information sharing on psychotropic medication practices. Many stakeholders may be involved in ensuring appropriate mental health treatments for children in foster care (see fig. 1).²³

Figure 1: Examples of Stakeholders That May Be Involved in Ensuring Appropriate Mental Health Treatments for Children in Foster Care



Source: GAO summary of information provided by HHS and officials from selected states and national professional and research organizations. | GAO-17-129

^aFor the purposes of our report, we refer to providers who are able to prescribe psychotropic medications and provide mental health services as “physicians.” These providers may be primary care physicians, pediatricians, psychiatrists, or other kinds of providers.

Note: Because each state may have a different structure for delivering child welfare and mental health services, all of these stakeholders may not be involved in a child’s mental health treatment and stakeholders may be associated with different local, county, state, or federal agencies. In addition, this graphic may not represent all stakeholders that may be involved.

²³For the purposes of our report, references to “stakeholders” can include those described in figure 1.

Psychotropic Medications and Other Mental Health Treatments for Children

Psychotropic medications can have significant benefits for those with mental health conditions by affecting brain activity associated with mental processes and behavior.²⁴ However, they can also have side effects ranging from mild to serious, depending on the class and type of medication used. According to the American Academy of Child & Adolescent Psychiatry (AACAP), medications for attention deficit hyperactivity disorder (ADHD), such as amphetamines (e.g., Adderall) and methylphenidate (e.g., Ritalin and Concerta), can reduce symptoms such as hyperactivity in children as well as improve their attention and increase their ability to get along with others.²⁵ These medications have been widely tested in children and are generally considered safe; however, ADHD medications have also been associated with side effects such as sleeplessness, loss of appetite, tics, agitation, hallucinations, liver problems, and suicidal thoughts. In addition, antidepressants, such as fluoxetine (e.g., Prozac) and sertraline (e.g., Zoloft) can be used to treat conditions such as depression and anxiety. However, possible adverse side effects include agitation, sleeplessness or drowsiness, and suicidal thoughts. The use of antipsychotics—one class of psychotropic medication—has been of particular concern. Antipsychotic medications, such as aripiprazole (e.g., Abilify) and risperidone (e.g., Risperdal), were developed to treat conditions such as bipolar disorder or schizophrenia.

²⁴The definition of what is considered a psychotropic medication can vary among states. Some states have developed lists that identify medications they consider to be psychotropic while others have not, for example, due to challenges with determining which medications to include. Among the available medication lists we examined in the seven states we selected for review, classes of medications included for most or all states include ADHD medications, anti-anxiety medications, anticonvulsants or mood stabilizers, antidepressants, antipsychotics, and hypnotics or sleep agents. Some states also include antihistamines, anti-hypertensives, and anti-Parkinson and dementia medications. Child welfare and Medicaid officials in one state explained that medications such as antihistamines and anti-hypertensives can be used for psychiatric purposes; however, if it is clear that the medication is being used for a non-psychiatric reason, the state may not consider it a psychotropic medication. While these states include similar classes of medications in their lists, they may not include all of the same medications in each class. In addition, child welfare and Medicaid officials in a few of the selected states said they were in the process of updating their lists, and officials in one state noted they use different lists depending on their purpose (e.g., examining trends in medication use versus determining which prescriptions are subject to additional reviews before they can be dispensed).

²⁵AACAP is a non-profit professional organization that promotes the healthy development of children, adolescents, and families through advocacy, education, and research, and helps meet the professional needs of child and adolescent psychiatrists throughout their careers. It has issued a number of resources and guidance for families, physicians, and government agencies on mental health treatments for children. See <http://www.aacap.org/>.

However, possible adverse side effects can be serious, including increased levels of cholesterol, rapid weight gain, and the development of diabetes or irreversible movement disorders.²⁶ Mental health researchers and others have stated the need for further research on the safety, effectiveness, and long-term effects of antipsychotics for children.

Psychosocial services are mental health treatments that generally involve therapy sessions with a mental health professional that are designed to reduce patients' emotional or behavioral symptoms. Such therapies may be used instead of, or in combination with, psychotropic medications to treat children with mental health conditions. Several large, federally funded studies have demonstrated that treatment with a combination of a psychosocial therapy and a psychotropic medication can be more effective than either treatment alone for certain conditions.²⁷ Further, psychosocial services shown to be effective in treating mental health conditions may be referred to as evidence-based therapies. While there is no standard definition of what constitutes "evidence-based," some federal agencies and provider organizations, such as SAMHSA and AACAP, evaluate and compile information on available therapies.²⁸

Guidance on Oversight of Psychotropic Medications

In response to concerns about psychotropic prescribing practices for children, especially involving those in foster care, AACAP has developed multiple resources to promote the appropriate and safe use of these medications. For physicians, AACAP issued best practice guidelines in

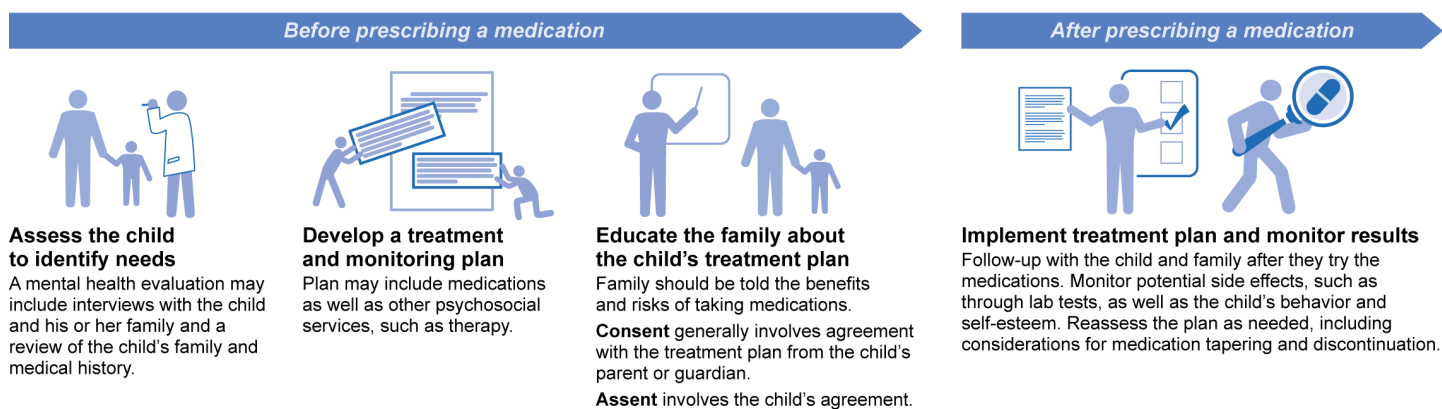
²⁶For example, a 2009 study of 272 children who were prescribed an antipsychotic medication found that after a median treatment period of nearly 11 weeks, children who had taken a medication had gained, on average, between 9.7 and 18.7 pounds compared to minimal weight gain by children who had refused medication. See C. Correll, P. Manu, V. Olshanskiy, B. Napolitano, J. Kane, and A. Malhotra, "Cardiometabolic Risk of Second-Generation Antipsychotic Medications During First-Time Use in Children and Adolescents," *JAMA*, vol. 302, no. 16 (2009).

²⁷See, for example, J. Walkup et al., "Cognitive behavioral therapy, sertraline, or a combination in childhood anxiety," *New England Journal of Medicine*, vol. 359, no. 26 (2008).

²⁸See, for example, SAMHSA's National Registry of Evidence-based Programs and Practices, a list of treatments that have been assessed by independent evaluators and rated on the strength of the evidence showing their effectiveness. <http://nrepp.samhsa.gov/>.

2009 that establish key activities before and after prescribing psychotropic medications to children (see fig. 2).²⁹

Figure 2: Activities for Physicians in Prescribing Psychotropic Medications to Children



Source: GAO summary of recommendations and guidelines on prescribing psychotropic medications to children by the American Academy of Child & Adolescent Psychiatry. | GAO-17-129

Building on these guidelines for physicians, AACAP developed best practice guidelines for states in 2012 and 2015, with support and partial funding from SAMHSA, that establish practices for overseeing the use of psychotropic medications for children in foster care as well as other children in state custody.³⁰ An overarching principle outlined in AACAP guidelines is that the use of psychotropic medications for these children should be part of a holistic and collaborative mental health treatment approach that recognizes (1) the biological, psychological, and social factors that may impact a child; (2) trauma-informed care principles that acknowledge the prevalence and impact of trauma, and a commitment to minimize its effects and avoid additional traumatization; and (3) child-serving agencies as part of a system of care for the child, and services that should be youth-guided, home and community-based, integrated across systems, data-driven, and outcome-oriented, among other things.

²⁹J. Walkup et al., "Practice Parameter on the Use of Psychotropic Medication in Children and Adolescents," *Journal of the American Academy of Child & Adolescent Psychiatry*, vol. 48, no. 9 (2009).

³⁰American Academy of Child & Adolescent Psychiatry, *A Guide for Community Child Serving Agencies on Psychotropic Medications for Children and Adolescents* (Feb. 12, 2012) and American Academy of Child & Adolescent Psychiatry, *Recommendations about the Use of Psychotropic Medications for Children and Adolescents Involved in Child-Serving Systems* (2015).

HHS issued an Information Memorandum to states in April 2012 to provide guidance to states on complying with the statutory requirement to develop protocols for the appropriate use and monitoring of psychotropic medications.³¹ The memorandum cited our previous work that raised concerns about states' efforts to oversee the use of psychotropic medications among children in foster care.³² This memorandum identified policy statements and guidelines from AACAP, the American Academy of Pediatrics, and the state of Texas, among others, and discussed consistent elements among these sets of guidelines. These elements, summarized below, include the need for state policies to contain provisions for:

- screening, assessment, and treatment planning mechanisms to identify children's mental health and trauma-treatment needs;
- informed and shared decision-making and methods for ongoing communication among the physician, child, family, and other key stakeholders;
- effective medication monitoring;
- availability of mental health expertise and consultation; and
- mechanisms for sharing up-to-date information and educational materials related to mental health and trauma-related interventions, including psychotropic medications.

³¹Administration for Children and Families, Information Memorandum, ACYF-CB-IM-12-03.

³²[GAO-12-201](#).

In addition to issuing this memorandum to states, we reported in April 2014 that ACF had worked collaboratively with CMS and SAMHSA to provide technical assistance; facilitate information sharing; and emphasize the need for collaboration among state child welfare, Medicaid, and mental health officials in overseeing psychotropic medications from January 2012 through July 2013.³³ Notably, these agencies cohosted a conference entitled “Because Minds Matter” in August 2012 that focused on collaborative medication monitoring as well as creating data systems to facilitate collaboration, among other things. According to ACF, CMS, and SAMHSA officials, the conference was an opportunity for states to talk and share practices, and representatives from 49 states attended.³⁴

Selected States Have Practices to Support the Prescribing Process and Educate Stakeholders on the Appropriate Use of Psychotropic Medications

³³[GAO-14-362](#).

³⁴A Florida child welfare official said that Florida officials were unable to attend the conference due to a hurricane.

Selected States Have Practices to Support Appropriate Treatment Decisions and Monitor the Child

Screenings

Officials we spoke with in the seven selected states told us they developed a variety of practices to better support appropriate mental health diagnoses and treatments for children in foster care in their states.³⁵ These range from requiring initial mental health screenings to monitoring children after they are prescribed psychotropic medications.³⁶

State officials in all seven of the selected states told us they require mental health screenings of children entering foster care, which is consistent with the guidelines on screenings identified in HHS guidance (see fig. 3).³⁷

³⁵Officials in this context refers to officials from state and county child welfare and Medicaid agencies and other partners. Practices described in this report may be required or recommended by state laws, regulations, child welfare or Medicaid agency policies, or guidance. These practices may apply to the oversight of all psychotropic medications for all children in foster care, may apply to all children on Medicaid, or may focus on children in foster care who are below a certain age or on certain types or combinations of medications. In this report, we describe practices required, recommended, or implemented at the state level. In states with county-administered programs, counties may vary in their implementation of practices recommended at the state level, and they may use additional oversight practices as well. This report does not examine county-level variation in oversight practices.

³⁶The states we selected were Arizona, California, Illinois, Maryland, New Jersey, Ohio, and Washington. For this review, we did not evaluate the effectiveness of the selected states' or counties' implementation of specific practices, their compliance with state or federal requirements, or whether there are controls in place to help ensure required practices are followed. See appendix II for further information on each state's practices. GAO compiled appendix II from information and documents provided to us by selected state agency officials. We did not independently verify the information provided, but gave officials the opportunity to review the content for accuracy. Additional oversight practices or measures may exist in these states that were not mentioned to us, and in some states, these practices and measures may vary by county.

³⁷Administration for Children and Families, Information Memorandum, ACYF-CB-IM-12-03. In addition, state Medicaid agencies are required to cover physical and mental health screenings under the Early and Periodic Screening, Diagnostic, and Treatment benefit. See 42 U.S.C. §§ 1396a(a)(43), 1396d(a)(4)(B) and (r).

Figure 3: Selected States' Practices to Assess Children's Mental Health Needs



Mental health screening

- For example, help children needing mental health services receive prompt treatment by providing referrals for a more comprehensive assessment, and provide the opportunity to collect health information for case management and tracking trends at the program level.

Required: State requires practice through state law, regulation, agency policy, or guidance

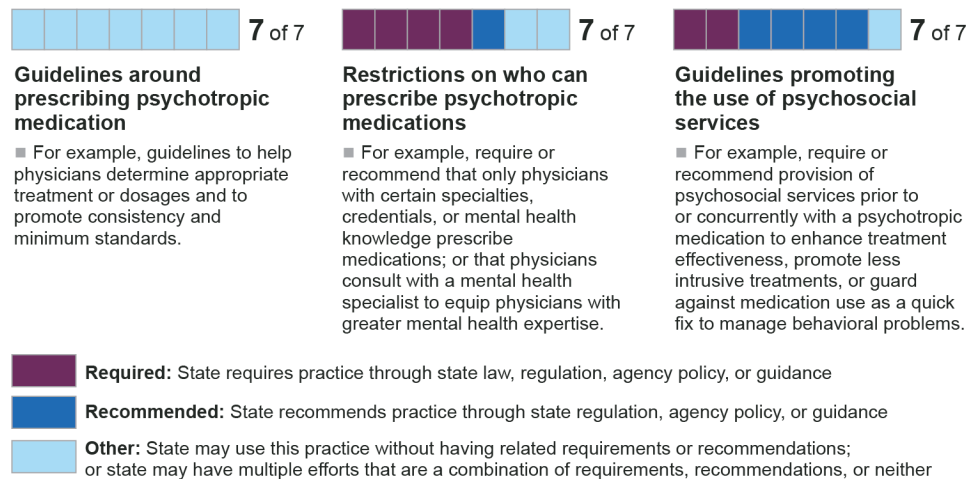
Source: GAO analysis of state-level information or documents collected from state officials in the seven selected states: Arizona, California, Illinois, Maryland, New Jersey, Ohio, and Washington. | GAO-17-129

For example, Washington officials told us that staff in their child welfare screening program are expected to screen children entering foster care within thirty days using validated tools, such as a trauma-related screen for anxiety and post-traumatic stress disorder, which have been tested and found to draw consistent results for the same child across multiple screeners. In addition, the screeners ask children whether they are taking psychotropic medications or receiving health services, and how their symptoms are progressing. Screeners then provide a report to caseworkers, who can follow up to ensure the child receives the appropriate referrals and services. Washington child welfare officials said they also use screening data to analyze how many children with mental health needs are receiving services. Arizona requires that children entering foster care receive a mental health screening within 72 hours to identify and provide services for any immediate mental health needs and reduce the child's stress and anxiety. Screenings are also to include provision of mental health services to each child's new caregiver. These services include guidance on how to respond to the child's immediate needs as the child transitions to foster care, information on mental health symptoms to watch for and report, assistance in responding to such symptoms, and provision of a contact in the mental health system. The child's caseworker is to be provided with findings and recommendations for needed mental health services. Illinois officials said their child welfare agency requires all children in foster care to receive a comprehensive health assessment from a licensed social worker and the child's caseworker within 55 days of entering the foster care system. According to these officials, this assessment should include a discussion of mental health issues and can prompt a referral for a psychiatric evaluation for the child.

Guidelines and Restrictions for Prescribing

State officials in the seven selected states said they have a variety of guidelines and restrictions to support appropriate mental health treatments for children in foster care (see fig. 4).

Figure 4: Selected States' Practices to Support Appropriate Treatments for Children



Source: GAO analysis of state-level information or documents collected from state officials in the seven selected states: Arizona, California, Illinois, Maryland, New Jersey, Ohio, and Washington. | GAO-17-129

State and county officials from some of the selected states described physicians' lack of knowledge of child and adolescent mental health issues as a challenge,³⁸ and officials in all seven states said they developed practices to promote effective treatment decisions.³⁹ For example, all seven of the selected states developed guidance on the use of psychotropic medications, such as dosage limits for children of different ages and weights, or medication lists that identify medications considered psychotropic.⁴⁰ All seven states also require or recommend restricting

³⁸We interviewed these officials using a semi-structured interview protocol, which included open-ended questions on some topics, including challenges related to psychotropic medication oversight. The answers provided by officials were volunteered in response to open-ended questions.

³⁹Throughout this report we describe the number of states providing responses using "a few" to represent two states, "some" to represent three to four states, and "most" to represent five to six states.

⁴⁰Washington officials told us a medical advisory group formulates this list for their state because medications may be used for different purposes. In addition, they said including too many medications increases the administrative burden on physicians and may inflate statistics on psychotropic medication use.

who can prescribe psychotropic medications, or require or recommend the physician consult a specialist in some cases. For example, in New Jersey, only a psychiatrist, pediatric neurologist, neurodevelopmental pediatrician, or an advanced practice nurse certified in psychiatry or mental health and collaborating with one of these specialists may prescribe psychotropic medications, except in cases of ADHD. In Maryland, if the prescribing physician is not a child psychiatrist, he or she must consult with or refer the child to a specialist before prescribing a psychotropic medication and within 60 to 90 days after making the initial prescription. In addition, Maryland officials said the state’s Medicaid agency contracts with mental health specialists at the University of Maryland to review all antipsychotic medication prescriptions for children in Medicaid.⁴¹

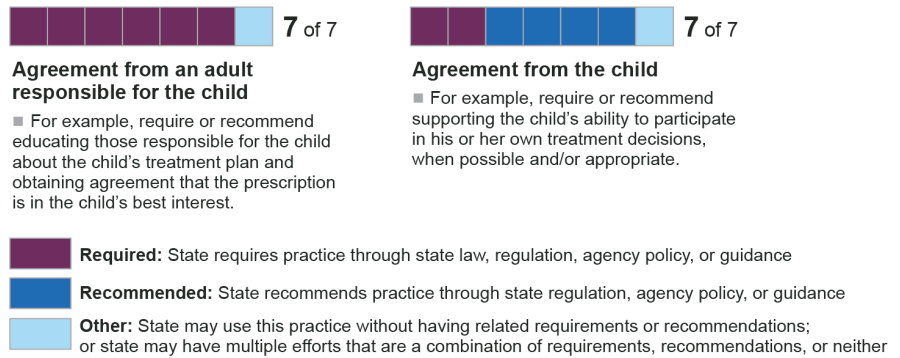
Agreement on Prescriptions

State officials in all seven of the selected states said they require or recommend that physicians obtain agreement—sometimes in writing—from an adult who has responsibility for the child in foster care (informed consent) and from the child (assent) on prescriptions for psychotropic medications (see fig. 5).⁴² These practices are among the consistent elements across guidelines identified by HHS on informed and shared decision-making.

⁴¹References to “mental health specialists” or “specialists” in this report may include health care providers with relevant specialties, such as child and adolescent psychiatrists, or specialized training or experience. Practices involving specialists’ review of medications prior to filling the prescription may be called prior authorization or second opinion. Washington officials said requiring secondary reviews decreased medication prescriptions because such reviews helped to educate physicians and support their response to foster parents or others who are concerned about difficult behaviors.

⁴²Depending on the state, an adult may be the parent, foster parent or other caregiver, child welfare agency official, judge, or some combination of the above. Each state has its own guidelines or requirements regarding which individuals are to provide consent. This practice is usually called informed consent, but may also be called authorization.

Figure 5: Selected States' Practices to Seek Agreement on a Child's Prescription



Source: GAO analysis of state-level information or documents collected from state officials in the seven selected states: Arizona, California, Illinois, Maryland, New Jersey, Ohio, and Washington. | GAO-17-129

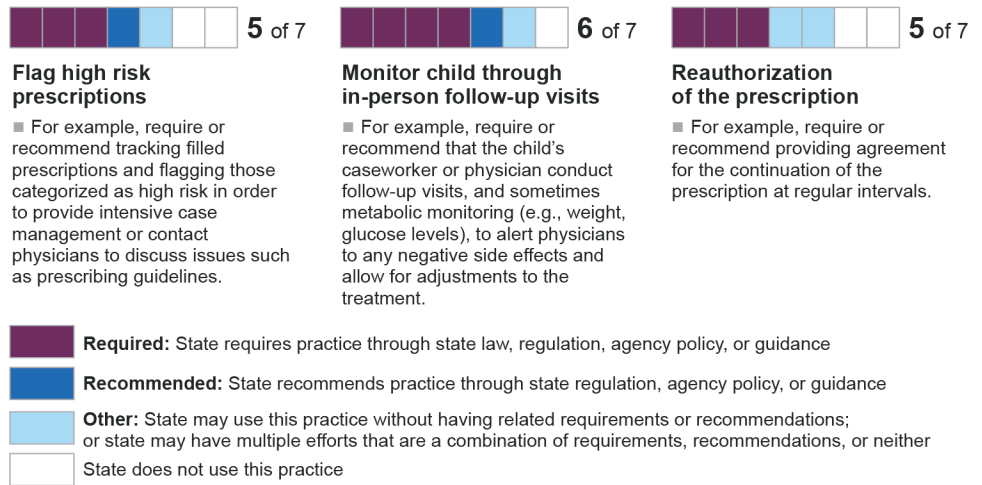
In Washington, the child welfare agency requires agreement from the parent if the child is under age 13, or from the child if he or she is age 13 or older. If the parent of a young child is unavailable, unable, or unwilling to consent, the child's caseworker must obtain a court order approving the use of psychotropic medication. In Maryland, caseworkers must collect a consent form signed by the parent or legal guardian as well as the child (if age 16 or older), when able. Similar to Washington, if the parent or guardian is unavailable or unwilling to provide consent, child welfare officials may obtain a court order in cases of medical necessity.

Ongoing Monitoring of the Child

State officials in all seven of the selected states said they have practices related to monitoring children: They track or recommend tracking of high-risk prescriptions, such as those involving antipsychotic medications or multiple medications taken at the same time, or they require or recommend periodic follow-up visits or reauthorization of certain prescriptions (see fig. 6).⁴³ Monitoring medication use for each child in foster care is one of the consistent elements across guidelines identified in HHS guidance.

⁴³For the purposes of this report, we use the term "high risk" to describe prescriptions identified by a state for additional oversight due to safety or other concerns. While these practices generally involve monitoring individual children, California officials said they are developing a related practice to monitor group homes. According to officials, the practice will involve quarterly reviews of data on psychotropic medication use among children living in congregate care and annual investigation of homes with high rates of use or where children have prescriptions flagged by Medicaid officials for review, such as psychotropic prescriptions for children under the age of 5.

Figure 6: Selected States' Practices for Ongoing Oversight of a Child's Prescriptions



Source: GAO analysis of state-level information or documents collected from state officials in the seven selected states: Arizona, California, Illinois, Maryland, New Jersey, Ohio, and Washington. | GAO-17-129

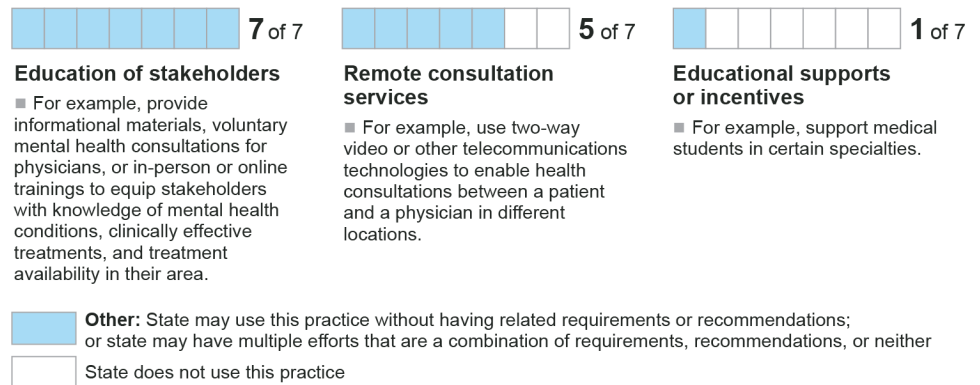
In Illinois, child welfare officials said their agency conducts ongoing oversight of prescriptions by examining a list of children taking antipsychotics and children under age 6 referred for uncommon conditions, such as aggression or bipolar disorder; consulting with mental health specialists; and referring cases for intensive case management, as needed.⁴⁴ California officials said county courts review psychotropic medications every 6 months, while in Maryland, officials said that, for children taking antipsychotic medications, they require physicians to monitor the child's height, weight, tremors, liver functioning, and blood sugar and lipid levels to identify side effects. They must then submit results to mental health specialists for review. In addition, Maryland caseworkers are required to review positive and negative effects of medications at their monthly home visits.

⁴⁴Related to this practice, California, New Jersey, and Washington officials said their states use nurses and other staff to perform health care case management services. According to New Jersey officials, nurses perform a mental health screen, track psychotropic medications and children's health status, and submit quarterly reports to the child welfare agency, among other activities. Washington officials said their care coordination staff provide services such as analyzing a child's records, assessing for gaps in care, facilitating access to health care providers, offering consultation to caseworkers and caregivers, and producing reports to help caseworkers develop the child's case plan.

Selected States Have Taken Steps to Increase Stakeholders' Mental Health Knowledge and Access to Related Services, but Concerns about Limited Access to These Services Remain

State officials in all seven of the selected states said they work to educate relevant stakeholders on mental health conditions and treatments.⁴⁵ Practices to educate stakeholders are among the consistent elements across guidelines identified by HHS on sharing information on mental health and trauma-related interventions with clinicians, child welfare staff, and consumers. In addition, officials in most of the selected states said their state works to increase access to mental health services for children in foster care (see fig. 7).⁴⁶

Figure 7: Selected States' Practices to Increase Stakeholders' Mental Health Knowledge and Access to Mental Health Services for Children



Source: GAO analysis of state-level information or documents collected from state officials in the seven selected states: Arizona, California, Illinois, Maryland, New Jersey, Ohio, and Washington. | GAO-17-129

State officials from five of the seven selected states said they provide relevant stakeholders with access to informational materials. For example, California maintains an online information bank of evidence-based treatments, and Ohio officials developed guides to help children and their families communicate with physicians and participate more actively in treatment decisions.⁴⁷ States may offer other types of

⁴⁵As explained earlier, stakeholders can include agency officials, physicians, foster parents, biological parents, and children in foster care.

⁴⁶We identified these efforts through interviews with officials in selected states' child welfare and Medicaid agencies and their partners, as referred to us. However, there may be additional state initiatives to increase access to mental health services that were not identified during our interviews.

⁴⁷Officials in some of the selected states described the education and empowerment of children and youth in foster care as important for protecting the interests and rights of the child.

informational resources as well. For example, Washington child welfare officials said they staff mental health specialists to a telephone hotline to provide physicians who call with consultations on mental health diagnoses and treatments as well as information about local service providers. In addition, officials said the state's child welfare agency and managed care provider offer in-person and online trainings on children's mental health, psychotropic medications and other mental health treatments, and the child welfare system.

State and county officials in four of the seven selected states and five of nine national organizations identified limited access to mental health services as a challenge.⁴⁸ These officials described a variety of factors limiting access, including insufficient numbers of professionals specializing in related fields, low Medicaid reimbursement rates, underserved rural areas, and physicians' limited knowledge of services available in their area.⁴⁹ As officials from one state explained, patients need access to a wider variety of evidence-based treatments. Other officials noted there are particular shortages among some specialties, such as child psychiatrists,⁵⁰ or needed training in areas such as trauma-

⁴⁸GAO has previously reported on challenges faced by children in foster care and more generally by Medicaid enrollees in accessing mental health services. See [GAO-13-15](#) and *Medicaid: Overview of Key Issues Facing the Program*, [GAO-15-746T](#) (Washington, D.C.: July 8, 2015). The Institute of Medicine reported that a shortage of mental health providers is a major factor affecting access to mental health services, especially for children. Institute of Medicine of the National Academies, Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders, *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series* (Washington, D.C.: 2006).

⁴⁹GAO reported in 2013 that families in rural areas may have more difficulty accessing mental health providers. GAO, *Child Welfare: States Use Flexible Federal Funds, but Struggle to Meet Service Needs*, [GAO-13-170](#) (Washington, D.C.: Jan. 30, 2013).

⁵⁰In 2011, we found that psychiatrists and psychologists were among the most difficult specialist referrals to obtain for children in low-income families covered by Medicaid. GAO, *Medicaid and CHIP: Most Physicians Serve Covered Children but Have Difficulty Referring Them for Specialty Care*, [GAO-11-624](#) (Washington, D.C.: June 30, 2011). Furthermore, we found in 2012 that among 55 surveyed states, U.S. territories, and the District of Columbia, respondents most frequently reported having difficulty ensuring sufficient Medicaid providers for psychiatry, among other specialties. GAO, *Medicaid: States Made Multiple Program Changes, and Beneficiaries Generally Reported Access Comparable to Private Insurance*, [GAO-13-55](#) (Washington, D.C.: Nov. 15, 2012).

informed care.⁵¹ To increase children’s access to mental health services, state and county officials in five of the selected states said they provide remote consultation services.⁵² In addition, Ohio state officials said the state offers fellowships for medical students in needed mental health specialties as well as training curricula for students to provide mental health services as part of primary care.⁵³

State Officials Said Collaboration, Outreach, and Gradual Rollout of New Practices Were Key to Effective Implementation

Officials in the seven selected states identified factors that helped them implement oversight practices for psychotropic medications, such as collaborating with other agencies, conducting outreach with relevant stakeholders, and gradually implementing new oversight practices. State officials in all seven of the selected states said strong collaboration among child welfare, Medicaid, or other partnering agencies was key to implementing these practices. Specifically, Washington officials said supporting children in foster care requires coordinated solutions across the agencies serving this population. In Ohio, officials said the directors of their child welfare, Medicaid, and mental health agencies have worked in the other agencies and as a result share resources and talent more easily and encourage open communication. In Washington, officials said strong collaboration allows their agencies to complement each other’s roles, develop more holistic practices, and implement oversight programs more effectively. Officials in Ohio and Washington attributed successful collaboration within their state to executive leadership support, the commitment and longevity of state agency leaders, and leaders’ and managers’ breadth of experience in multiple agencies and front-line roles. Washington officials emphasized the importance of developing integrated programs in order to institutionalize collaboration.

⁵¹HHS highlighted the importance of trauma-informed care for children in foster care in its 2013 tri-agency letter to states on trauma. HHS reported on the central role of exposure to trauma on mental and physical health and substance use disorders. HHS found that a lack of trauma-informed care may have a direct impact on psychotropic medication use among children in foster care. See <https://www.medicicaid.gov/federal-policy-guidance/downloads/smd-13-07-11.pdf>.

⁵²These services, often called telemedicine, may use two-way video or other telecommunication technologies to enable health consultations between a patient and a physician in different locations. Such services can be particularly useful to address a lack of access in rural areas.

⁵³Related to this practice, Ohio officials said the state manages a loan repayment program for psychiatrists who choose to work in regional state hospitals.

State and county officials in three of the seven selected states said conducting outreach helped them educate stakeholders on relevant issues and requirements and gain stakeholders' buy-in. For example, Maryland officials said conducting extensive outreach to physicians on how to best implement new requirements for medication approval and monitoring helped ensure stakeholder adoption of the program and was essential to its success. These officials said they shared information with physicians about antipsychotic medications, monitoring side effects, and available psychosocial services. In response to physicians' feedback, Maryland officials said they adapted the program to allow physicians to call in required information over the phone to avoid having to complete forms.

Officials in two of the selected states said the gradual rollout of new practices enabled mid-course corrections or supported higher rates of adoption or compliance with the practice. For example, Ohio officials said they developed their medications oversight program in several stages. One step entailed a pilot program that flagged potentially inappropriate prescriptions and required physicians to consult with mental health specialists. Through this program, officials said they identified a lack of mental health knowledge and access to mental health specialists as two causes of inappropriate prescriptions. They said they redesigned their oversight practices to address these causes, tested the new practices, and are now implementing them statewide.

While Some Selected States Reduced the Use of Psychotropic Medications, They All Focused on Other Measures to Gauge the Results of Their Efforts

Some Selected States Reduced Psychotropic Medication Use, though Mental Health and Foster Care Stakeholders Said Reducing Medications May Not Be Appropriate for Every Child

Our analysis of available data from the seven selected states show that four of these states—California, Illinois, New Jersey, and Washington—reduced the percentage of children in foster care on psychotropic medications from 2011 through 2015.⁵⁴ Two other selected states—Arizona and Maryland—had steady rates of medication use.⁵⁵ Ohio did not have data for this time period.⁵⁶ Because states use different

⁵⁴California child welfare and Medicaid officials expressed concern that their Medicaid data could undercount the number of claims made for children in foster care. These officials said information indicating whether a child is in foster care may not always be available in their Medicaid data system, and this information cannot completely be reconciled with their child welfare data system.

⁵⁵For the purposes of our report, we categorized a state as having a steady rate of medication use if the percentage of children in foster care on psychotropic medications fluctuated by less than 1 percent for each year from 2011 through 2015.

⁵⁶Ohio child welfare officials said they did not regularly collect data on the use of medications in the past, but began to do so as of May 2016.

methodologies to collect data, these data cannot be compared across states.⁵⁷

While identifying all the factors that contribute to reduced medication use can be difficult,⁵⁸ Washington child welfare and Medicaid officials said their second opinion program, which requires physicians to consult a child psychiatrist when prescribing certain medications, has likely prevented inappropriate prescribing. A 2009 study on this program also found that it helped reduce ADHD medications that were provided in high doses, in combinations, and for children under 6.⁵⁹

Child welfare and Medicaid officials in some selected states and officials from most national professional and research organizations we interviewed said reducing medications may not be appropriate for every child. For example, child welfare and Medicaid officials in one selected state explained that without medication, a child in foster care may not be able to sit through a therapy session or perform in school. In addition, officials in all seven states said a child's mental health can be affected by many factors, including psychotropic medications, psychosocial services, and other situational and environmental factors. Rather than focusing on reducing medications overall, officials in these states said their goal is to ensure the child receives appropriate treatment, which may involve efforts related to all of the factors mentioned above.

⁵⁷ Specifically, selected states collect information on different populations of children in foster care (e.g., children from birth to age 18 in one state versus ages 3 to 17 in another state because it received a grant that focused on this population) and report information for different time periods (e.g., calendar year from January 1 through December 31 versus state fiscal year from July 1 through June 30). One state reports data quarterly rather than annually. Since this state provided data to us for the same quarter of each year, our calculations on percentages of children in foster care on psychotropic medications are likely unaffected. In addition, four of the six selected states that were able to provide data were unable to provide data for all years from 2011 through 2015. Specifically, one state was unable to provide data for 2011, one state conducted two point-in-time studies that did not include data for 2011 and 2015, and two states had time lags in reporting that precluded them from providing data for 2015.

⁵⁸ Examples of factors that can contribute to reductions in medication use include state oversight practices, changes in the numbers of children in foster care, changes in the mental health needs of this population, and changes to the types of medications considered psychotropic.

⁵⁹ This study examined over 1,000 second opinion reviews provided from May 2006 through April 2008. J. Thompson, C. Varley, J. McClellan, R. Hilt, T. Lee, A. Kwan, Taik Lee, and E. Trupin, "Second Opinions Improve ADHD Prescribing in a Medicaid-Insured Community Population," *Journal of the American Academy of Child & Adolescent Psychiatry*, vol. 48, no. 7 (2009).

States Use Information on Physician Prescribing Patterns and State Oversight Practices to Gauge Results, though Data Sharing Can Be a Challenge

Child welfare and Medicaid officials in all seven of the selected states told us they use a variety of measures to gauge the results of their efforts related to psychotropic medication use among children in foster care.⁶⁰ These measures generally examine physician prescribing patterns, state oversight practices, and child placement, health, education, and juvenile justice outcomes. For additional information on measures collected by each selected state, see appendix II.

- **Physician prescribing patterns.** All seven selected states examine data to better understand certain prescribing patterns, such as the use of antipsychotics, the use of multiple psychotropic medications at the same time, and dosage levels for the medications prescribed. Child welfare and Medicaid officials in all of these states said they have particularly focused on antipsychotic medications, in part due to concerns about inappropriate use of these medications and their potential negative side effects for children. Officials in five states told us their state has experienced reductions in antipsychotic use among children in foster care in recent years. Researchers have also noted that concerns about the use of antipsychotic medications spurred state efforts to oversee and improve prescription behavior, and a June 2016 study examining Medicaid data in 20 states from 2005 through 2010 found that trends in the use of these medications are no longer increasing.⁶¹ However, the study noted that current prescribing patterns for antipsychotics at the “new normal” rates of use remain of great concern to many stakeholders.

Child welfare and Medicaid officials in one state also underscored the significance of examining prescribing patterns after they observed spikes in the use of certain medications. These officials said that after their state started requiring second opinions for ADHD prescriptions, they saw increases in prescriptions of antipsychotics, and after requiring second opinions on antipsychotics, they saw increases in prescriptions for the use of multiple psychotropic medications at the

⁶⁰The measures discussed are collected by state child welfare, Medicaid, and/or other agency officials, depending on the state. We focused our review on state-level data to examine the results of selected state efforts, although counties may also collect data on these and other measures. State officials told us about the measures they collect, and provided examples of reports on these measures. The selected states vary in how frequently they examine their measures (e.g., monthly reports versus one point-in-time report).

⁶¹S. Crystal, T. Mackie, M.C. Fenton, S. Amin, S. Neese-Todd, M. Olfson, and S. Bilder. “Rapid Growth of Antipsychotic Prescriptions For Children Who Are Publicly Insured Has Ceased, But Concerns Remain” *Health Affairs*, vol. 35, no. 6 (2016): 974-982.

same time. Officials interpreted these patterns as showing that some physicians choose to prescribe certain medications partly to avoid their state's oversight practices. These officials expressed concern that new requirements may cause increased medication use in other areas, which would need to be monitored.

- **State oversight practices.** While selected states may have similar reported practices for overseeing the use of psychotropic medications, they vary in whether they examine data to determine if their practices are followed. For example, while child welfare and Medicaid officials in all seven states told us their state requires some form of agreement or informed consent for a child's treatment plan, officials in three of these states told us they review reports on whether such an agreement was obtained. In addition, while officials in six states said their state requires or recommends a caseworker or physician conduct follow-up visits with a child on psychotropic medications, officials in one of these states told us they examine data on the required follow-up, specifically for ADHD medications.⁶² Officials in three of these states told us they do examine data on whether a physician monitors the child's metabolic health, including height, weight, and lipid panels. These measures can be used to monitor whether a child is experiencing any adverse effects as a result of taking medications. Child welfare and Medicaid officials in most selected states said they have particularly focused on ensuring children in foster care receive psychosocial services to help address experiences with trauma. Officials in all seven states said their state has guidelines that require or recommend the use of psychosocial services prior to or concurrently with a psychotropic medication, and officials in all of these states told

⁶²Officials in the state that did not report having requirements or recommendations for follow-up visits told us they examine data on physician follow-up for children in foster care who are prescribed new psychotropic medications or ADHD medications. Examining physician follow-up for ADHD medications is one of several standardized health performance measures set by the National Committee for Quality Assurance under the Healthcare Effectiveness Data and Information Set (HEDIS). The committee is a non-profit organization that works to improve health care quality. It developed HEDIS as a tool for health organizations to measure performance on dimensions of care and service. HEDIS consists of 81 measures across 5 domains of care, including effectiveness of care. These measures are specifically defined to allow for comparisons of performance across health organizations. The measure examining physician follow-up for ADHD medications is also included as part of CMS's Core Set of Children's Health Care Quality Measures. These measures were established in response to the Children's Health Insurance Program Reauthorization Act of 2009, which requires HHS to identify and publish a core set of children's health care quality measures for voluntary use by state Medicaid and other children's health programs.

us they examine data on the number of children in foster care who received such services. Officials in four of these states told us their state has increased the use of psychosocial services. For example, a 2013 study on physicians' use of Washington's telephone line for mental health consultations between 2008 and 2011 found a 132 percent increase in outpatient mental health visits for children currently or previously in foster care after a consultation.⁶³ However, as mentioned earlier, child welfare and Medicaid officials in most of the selected states—as well as multiple studies—have noted continuing challenges with access to psychosocial services.

While we did not assess states' implementation of specific practices to oversee the use of psychotropic medications, findings from a 2016 California State Auditor report highlight the importance of having measures in place to ensure that state practices are followed.⁶⁴

Specifically, the report found multiple cases where children in foster care received prescriptions for psychotropic medications without court authorization or parental consent, which, according to the report, is a violation of state law.

- **Child placement, health, education, and juvenile justice outcomes.** Most of the seven selected states collect data to monitor outcomes for children on psychotropic medications. For example, child welfare and Medicaid officials in four selected states told us they monitor information on whether a child in foster care on psychotropic medications experiences a placement disruption (the child is moved from one placement to another). Multiple studies have shown that placement disruptions are associated with increased mental health needs⁶⁵ and poor social-emotional outcomes,⁶⁶ and that problem

⁶³R. Hilt, M. Romaine, M. McDonell, J. Sears, A. Krupski, J. Thompson, J. Myers, E. Trupin, "The Partnership Access Line: Evaluating a Child Psychiatry Consult Program in Washington State," *JAMA*, vol. 167, no. 2 (2013).

⁶⁴California State Auditor, *California's Foster Care System: The State and Counties Have Failed to Adequately Oversee the Prescription of Psychotropic Medications to Children in Foster Care*, Report 2015-131 (Sacramento, CA: Aug. 23, 2016). The report findings are based on 80 case file reviews conducted by state auditors in four counties, including two that we reviewed, among other methods.

⁶⁵See, for example, S. James, J. Landsverk, D. Slymen, and L. Leslie, "Predictors of Outpatient Mental Health Service Use—the Role of Foster Care Placement Change," *Mental Health Services Research*, vol. 6, no. 3 (2004) and D. Rubin, E. Alessandrini, C. Feudtner, D. Mandell, A.R. Localio, and T. Hadley, "Placement Stability and Mental Health Costs for Children in Foster Care," *Pediatrics*, vol. 113, no. 5 (2004).

behavior can be an indicator of risk for future placement disruptions.⁶⁷ Since children may be prescribed psychotropic medications to help treat problem behaviors, examining data on disruptions can help states better understand whether children with problem behaviors on medications are improving or are still having serious behavioral problems. Some states also examine health, education, and juvenile justice outcome measures for children in foster care on psychotropic medications. Child welfare and Medicaid officials in a few states said such measures can help them determine whether the care and services provided to children in foster care are helping these children lead healthy and productive lives.⁶⁸ For example, Illinois child welfare officials told us they examine whether a child under the age of 6 on a psychotropic medication has symptoms of self-harm or is hospitalized. In addition, Maryland child welfare officials told us they examine data on school enrollment and academic performance for children in foster care on psychotropic medications, whereas Washington officials told us they examine data on whether children in foster care with mental health needs, including those on psychotropic medications, have any involvement in the juvenile justice system.

Child welfare and Medicaid officials in most of the seven selected states discussed common challenges in their efforts to collect data needed to oversee the use of medications by children in foster care and to monitor outcomes for these children. In five of the seven states, officials discussed technical issues with obtaining reliable data. They said data on psychotropic medications and other mental health services for children in foster care can involve data systems from state child welfare, Medicaid,

⁶⁶See, for example, E. Lewis, M. Dozier, J. Ackerman, and S. Sepulveda-Kozakowski, "The Effect of Placement Instability on Adopted Children's Inhibitory Control Abilities and Oppositional Behavior," *Developmental Psychology*, vol. 43, no. 6 (2007) and J. Ryan and M. Testa, "Child Maltreatment and Juvenile Delinquency: Investigating the Role of Placement and Placement Instability," *Children and Youth Services Review*, vol. 27 (2005).

⁶⁷See, for example, P. Fisher, M. Stoolmiller, A. Mannering, A. Takahashi, and P. Chamberlain, "Foster Placement Disruptions Associated With Problem Behavior: Mitigating a Threshold Effect," *Journal of Consulting and Clinical Psychology*, vol. 79, no. 4 (2011) and S. Leathers, "Placement Disruption and Negative Placement Outcomes among Adolescents in Long-term Foster Care: The Role of Behavior Problems," *Child Abuse and Neglect*, vol. 30 (2006).

⁶⁸Several research and advocacy organizations also examine similar outcome measures for children in the general population. For example, the Annie E. Casey Foundation's KIDS COUNT Data Center is an online resource that provides data on the educational, social, economic, and physical well-being of children over time at the national and local levels. See <http://www.aecf.org/work/kids-count/>.

and mental health agencies. In addition, they said data needed to gauge whether a child's life improves with treatment—such as the child's living situation and their health, education, and juvenile justice outcomes—can involve many other data systems, including those from state education and juvenile justice agencies.⁶⁹ Because some of these agencies may not collect information specifically on the foster care population, officials said gathering these data may require data matching across these systems. In some selected states, officials said this information may also involve county-level agencies that can vary in the types of data they collect as well as one or more third-party managed care organizations that report to state Medicaid agencies. These officials said matching such data can be difficult and time-consuming, and state child welfare and Medicaid officials in three selected states discussed limitations with data gathering due to resource and time constraints, given other competing priorities.

State child welfare and Medicaid officials in five selected states also discussed privacy concerns related to data sharing. For example, officials in two of these states said state agencies are reluctant to share sensitive data on individuals due to their concerns about privacy protections under the Health Insurance Portability and Accountability Act of 1996 for health information⁷⁰ and the Family Educational Rights and Privacy Act for

⁶⁹Specifically, child welfare and Medicaid officials in three selected states discussed the importance of data on a child's stability in their living situation, including information on placement disruptions, whether the child returns home, and whether the child becomes homeless; officials in two selected states discussed the need for health outcomes data for children in foster care, including rates of hospitalizations, emergency room visits, and relapses; officials in six states discussed the need for information on education outcomes for these children, including enrollment and graduation rates; officials in one state expressed interest in whether these children become involved in the juvenile justice system; and officials in another state were interested in whether a child is able to obtain employment after leaving the foster care system. As discussed earlier, some selected states may already be collecting data on these measures.

⁷⁰The Health Insurance Portability and Accountability Act of 1996 required HHS to promulgate regulations addressing the privacy and security of health information. Pub. L. No. 104-191, tit. II, subtit. F, 110 Stat. 1936, 2021-34 (codified at 42 U.S.C. §§ 1320d-1320d-8). HHS has published Standards for Privacy of Individually Identifiable Health Information (the Privacy Rule) and Security Standards for the Protection of Electronic Protected Health Information (the Security Rule). See 45 C.F.R. pts. 160 and 164. The Privacy Rule establishes national standards for safeguarding individually identifiable health information that is transmitted or maintained in any form or medium (protected health information). The Security Rule establishes nationwide standards for safeguarding protected health information that is held or transferred electronically.

education information.⁷¹ Similarly, officials in two other states expressed uncertainty over the types of data they were able to share under state and federal laws.⁷² Child welfare and Medicaid officials in three of the five counties where we conducted interviews discussed similar privacy concerns with data sharing among county-level agencies. Child welfare and Medicaid officials in two of the five states that expressed privacy concerns also discussed concerns about sharing data with managed care organizations. They said they were in the process of determining how to share information specifically on the foster care population with these organizations as well as what data to collect from them.

State child welfare and Medicaid officials in some selected states that were able to share data said they overcame privacy concerns through negotiating written agreements and educating stakeholders about sharing data consistent with state and federal privacy requirements. For example, Maryland child welfare and Medicaid officials said their agencies each formed an agreement to share data with the same contractor, who matched data on children in foster care with Medicaid data on claims for psychotropic medications and mental health services, and reported the

⁷¹The Family Educational Rights and Privacy Act requires educational agencies and institutions that receive U.S. Department of Education funds—such as schools, school districts, colleges, and universities—to provide parents and eligible students with access to education records and generally prohibits the disclosure of education records without the prior written consent of the parent or eligible student, unless an exception to the general consent requirement applies. See 20 U.S.C. § 1232g and 34 C.F.R. pt. 99.

⁷²Various GAO reports have outlined challenges states have faced in navigating federal privacy and security protections for health, child welfare, education, and other data. See, for example, GAO, *Prescription Drug Data: HHS Has Issued Health Privacy and Security Regulations but Needs to Improve Guidance and Oversight*, [GAO-12-605](#) (Washington, D.C.: June 22, 2012); *Human Services: Sustained and Coordinated Efforts Could Facilitate Data Sharing While Protecting Privacy*, [GAO-13-106](#) (Washington, D.C.: Feb 8, 2013); and *Postsecondary Education: Many States Collect Graduates' Employment Information, but Clearer Guidance on Student Privacy Requirements Is Needed*, [GAO-10-927](#) (Washington, D.C.: Sept. 27, 2010). In response to GAO recommendations from these reports, HHS issued guidance in November 2012 to assist entities covered by the Health Insurance Portability and Accountability Act of 1996 in ensuring that protected health information, such as Medicaid beneficiaries' use of prescription drugs, could not be linked to a particular individual when used for purposes other than directly providing clinical care to an individual. HHS published a "Confidentiality Toolkit" in August 2014 that aims to support state and local data sharing efforts by bringing greater clarity to the rules governing confidentiality in certain human services programs, and the Department of Education revised its Family Educational Rights and Privacy Act regulations in December 2011 to, among other things, clarify the means by which states can collect and share graduates' employment information consistent with federal requirements. The Department of Education also published a "Data Sharing Toolkit" for states and other community leaders in March 2016.

information to state agencies without providing personal data. In addition, Maryland child welfare officials said their agency entered into an agreement with their state education agency to share education information for children in foster care. This agreement granted certain officials access to personal information, and these officials assigned anonymous identifiers to each child to protect their privacy while facilitating data sharing. California child welfare officials told us they recently worked with their state education and juvenile justice agencies to issue a letter that summarizes existing state and federal laws that pertain to the sharing of information and records between local education agencies, county child welfare agencies, and caregivers for children in foster care. In addition, Washington child welfare officials discussed data sharing agreements among multiple state agencies that allowed the state to match and share client-level information across more than 30 state data systems.⁷³ These officials attributed the success of their agreements to strong state leadership and the development of trust and buy-in among the stakeholders involved.

HHS Assists States in Addressing Medication Use and the Mental Health Needs of Children, Though More Could Be Done to Support Collaboration across State Agencies

⁷³Examples of state agencies contributing to this database include Washington's Department of Social and Health Services for data on child welfare services, Health Care Authority for data on Medicaid and health benefits, Department of Corrections for data on incarcerations, Education Research Data Center for data on school outcomes, and Department of Commerce for data on housing assistance and homelessness.

HHS Supports States in Overseeing Medication Use and Determining Children’s Mental Health Needs and Treatment Options

States’ Practices to Oversee Medication Use

Since our 2014 review of psychotropic medications for children in foster care,⁷⁴ ACF, CMS, and SAMHSA have continued to provide support to states—generally in the form of funding and technical assistance—to assist with oversight of these medications. Specifically, these efforts aim to support states’ practices for prescribing medications, for diagnosis and treatment options, and for implementing measures to assess the quality of health care delivery to children in foster care.

Through funding and information sharing, SAMHSA, CMS, and ACF help state agencies with practices related to prescribing medication and their oversight efforts. For example, SAMHSA partly funded AACAP’s development of voluntary recommendations for states on the use of psychotropic medications for children and adolescents.⁷⁵ As discussed earlier, these recommendations emphasize that holistic mental health treatment can include medication, but that medication should be only one part of the overall plan. State officials in most of our selected states said they reviewed AACAP recommendations when developing their own guidelines and oversight practices for children in foster care. For example, child welfare officials in Illinois said they worked with a representative of their state AACAP branch, among others, to develop guidelines on prescribing medications, which, according to these officials, were included in their state law. In addition, Ohio’s medication management and oversight program included clinical resources and prescribing guidelines for physicians based on AACAP’s recommendations.

SAMHSA also supports child welfare agency staff and mental health stakeholders seeking to ensure the appropriate use of psychotropic medications for children in foster care through a contract with the Technical Assistance Network at the University of Maryland’s School of Social Work. SAMHSA funds a medical director position at the network, and that director works with 55 child and adolescent psychiatrists in state and county governments to address issues regarding psychotropic medication, including strategies to help ensure children receive

⁷⁴[GAO-14-362](#).

⁷⁵*Recommendations about the Use of Psychotropic Medications for Children and Adolescents Involved in Child-Serving Systems*, 2015. These recommendations apply to all children and adolescents, including those in foster care. They cover three areas—clinical practice, psychotropic medication oversight, and research. In addition to these recommendations, AACAP developed several other resources that address these and other related topics.

appropriate treatment. Specifically, the director created a community listserv of child and adolescent psychiatrists to disseminate best practices and developed webinars on medication oversight. According to SAMHSA officials, the medical director, with input from the listserv community, is developing guidance on how to take youth off medication, an issue that child welfare officials in one selected state said can be a challenge. As these officials explained, psychiatrists generally are reimbursed more for medication management than psychotherapy, which can create a disincentive for keeping children off medication.⁷⁶ Through the network's Clinical Distance Learning Series, SAMHSA also developed webinars and issue briefs on the oversight of psychotropic medications for children on Medicaid, including one on developing performance measures. According to SAMHSA officials, the technical assistance network has also begun planning for a multi-year collaborative for residential treatment centers that have an interest in addressing the use of antipsychotic medications among the youth they serve.⁷⁷ As they explained, the goal of this group is to increase best practices related to the use of antipsychotic medications for youth in residential care and reduce outlier practices, such as prescribing children too many medications or at dosages exceeding maximum levels based on labels approved by the Food and Drug Administration. Through funding, SAMHSA has continued to support a multi-year virtual learning community in which community participants receive technical assistance, including monthly e-newsletters, webinar invitations, and access tools and resources.⁷⁸ SAMHSA-funded webinars

⁷⁶Researchers in one study noted that a significant decline in the provision of psychotherapy by psychiatrists in the United States was attributed to a decrease in the number of psychiatrists specializing in psychotherapy and a corresponding increase in those specializing in pharmacotherapy. Further, it was noted that changes were likely motivated by financial incentives—that is, reimbursement policies favoring brief medication management visits rather than psychotherapy—and the introduction of newer psychotropic medications with fewer adverse effects. R. Motjabai and M. Olfson. "National Trends in Psychotherapy by Office-Based Psychiatrists" *Archive of General Psychiatry*, vol. 65, no. 8 (2008): 962-970.

⁷⁷As discussed earlier, residential treatment facilities are for youth who may require intervention to address emotional or behavioral challenges and are generally established by state agencies or private companies.

⁷⁸The virtual learning community was developed by the non-profit organization Center for Health Care Strategies as part of its initiative on "Improving the Use of Psychotropic Medications among Children and Youth in Foster Care." The center conducted a three-year quality improvement collaborative that included participation by Illinois, New Jersey, New York, Oregon, Rhode Island, and Vermont. Each state convened a cross-agency team, including state Medicaid, child welfare, and mental health agencies as well as families, youth, and physicians, to develop and implement new approaches to psychotropic medication use for children.

have included issues such as cross-system data sharing, education and engagement of key stakeholders, phone psychiatric consultation models, and red flag and response systems for medication oversight.

CMS, in its 2015 Quality Conference, hosted a Medicaid Track that included a session for Medicaid and health care professionals on physician prescribing patterns considered high risk because of the adverse side effects, including the use of antipsychotic medications. The National Committee for Quality Assurance, a nationally recognized quality improvement entity, presented the results of its efforts to develop measures to oversee medication use at the conference.⁷⁹ According to CMS officials, this session prompted formation of a group for interested state Medicaid agencies and their partners on the use of antipsychotic medications for children. Eight states are participating in the group as of October 2016. These states are working on various projects to improve appropriate medication use and monitoring for possible side effects.⁸⁰ In addition, in February 2016, CMS collaborated with the National Association of Medicaid Directors and the American Drug Utilization Review Society to host a national call for 12 Medicaid drug utilization review program directors to share their strategic efforts on their child antipsychotic monitoring programs with all other states and the District of Columbia.

ACF developed two guides related to psychotropic medication use for children in foster care. The first guide provides tools to help children ask questions about medications as they meet with physicians. The second publication is a companion guide for child welfare staff and foster parents on mental health issues, the impact of trauma, and psychotropic medications.⁸¹ According to ACF officials, both guides have been

⁷⁹This collaborative was led by the Medicaid Medical Directors Network. The first data project began in 2007 and included 16 states. The follow-on project in 2011 involved nine states: Colorado, Maine, Missouri, New Hampshire, New York, Oklahoma, Pennsylvania, Tennessee, and Washington.

⁸⁰According to CMS officials, the working group includes a mix of large and small population states as well as those with fee-for-service and managed care delivery models.

⁸¹Children's Bureau et al. *Making Healthy Choices: A Guide on Psychotropic Medications for Youth in Foster Care* (Washington, D.C.: Children's Bureau, Administration for Children and Families, Department of Health and Human Services, 2012). Also, Children's Bureau et al. *Supporting Youth in Foster Care: Making Healthy Choices* (Washington, D.C.: Children's Bureau, Administration for Children and Families, Department of Health and Human Services, 2015).

Diagnosis and Treatment
Options

distributed nationally and are posted on ACF's Child Welfare Information Gateway website.

HHS also helps states address mental health screenings for children—which affects their diagnosis and treatment options—and increase awareness of and access to trauma-informed care services among the child welfare workforce.

Misdiagnosis and inappropriate medication use: ACF and the Centers for Disease Control and Prevention partnered to study the relationship between misdiagnosis and inappropriate medication use. Their study was spurred by prior research that examined a large sample of children in a child welfare population who underwent a comprehensive diagnostic evaluation. The prior study found that over 85 percent of children diagnosed with fetal alcohol spectrum disorder had never been previously diagnosed or had been misdiagnosed. For these children, the most common mental health diagnosis prior to the comprehensive evaluation was ADHD—a diagnosis that often leads to psychotropic medication prescriptions.⁸² ACF and the Centers for Disease Control and Prevention are currently completing a pilot study at a local child welfare agency to understand why a diagnosis of fetal alcohol spectrum disorder might be missed and what information agencies and families need in order to maximize outcomes for children and families. According to ACF officials, they also plan to gather information from other sites to understand this issue at a national level, and to develop training materials for caseworkers and caregivers on a child's likely prenatal exposure to

⁸² J. Chasnoff, A. M. Wells, and L. King "Misdiagnosis and Missed Diagnoses in Foster Care and Adopted Children with Prenatal Alcohol Exposure," *Pediatrics*, vol. 135, no. 2, (2015): 264-270. Data were collected from a sample of 547 adopted children and those in foster care who underwent a comprehensive multidisciplinary diagnostic evaluation. Among 156 children and adolescents who met criteria for a diagnosis within the fetal alcohol spectrum disorder, 125 had never been diagnosed as affected by prenatal alcohol exposure, a missed diagnosis rate of 80.1 percent. Within this clinical sample, 86.5 percent of youth with fetal alcohol spectrum disorder had never been previously diagnosed or had been misdiagnosed. According to the study, high rates of missed diagnoses and misdiagnosis have significant implications for intervention and therapeutic services. According to ACF officials, children with fetal alcohol spectrum disorder can present behaviors which often lead them to be incorrectly identified as having ADHD.

alcohol as well as the types of information that caseworkers and caregivers need to help these children.⁸³

Trauma-informed care and evidence-based practices: ACF provides a variety of trauma-related grants, including grants focused on screening, assessment, treatment, and bridging the gaps between child welfare and mental health.⁸⁴ Through support of another ACF grant, the National Center for Evidence Based Practice in Child Welfare provides training and capacity building for child welfare and mental health staff on trauma-focused therapy and on improving access to mental health services.⁸⁵ In Washington, the state used ACF’s informational briefs on trauma for its own training and ACF grant funds to develop a handbook on trauma for foster care families.⁸⁶

SAMHSA also provided competitive grants to a cohort of states to help increase quality of care and access to trauma-related services.⁸⁷ In 2014,

⁸³The ACF and Centers for Disease Control and Prevention study indicated that foster parents and child welfare agency staff often do not understand that typical child rearing approaches are not effective with these children. Instead, they need training to learn the best approaches to improve children’s outcomes.

⁸⁴These trauma-related discretionary grants were initially awarded in three clusters, in 2011, 2012, and 2013, and include 20 grantees from local, county, or state governments. The first cluster focuses on screening and assessment upon entry into foster care. The second cluster focuses on determining the availability of evidence-based practices, in addition to screening and assessment. The third cluster focuses on transition services for children preparing for adoption. Grantees conduct an evaluation of child welfare outcomes. According to ACF officials, ACF is just beginning to see results. Among the recipients of these grants are university, hospital, and county government entities in three of the seven selected states we included in this review. These grants were made pursuant to HHS’s authority under section 203 of the Child Abuse Prevention and Treatment Act, codified as amended at 42 U.S.C. § 5113.

⁸⁵The National Center for Evidence Based Practice in Child Welfare implemented a program called Partnering for Success, which began in 2014 and has been implemented in four states, according to ACF officials.

⁸⁶The handbook was developed as part of Washington’s “Creating Connections” project, supported by one of ACF’s trauma-related grants.

⁸⁷SAMHSA funded these competitive grants through the Donald J. Cohen National Child Traumatic Stress Initiative, authorized by the Children’s Health Act of 2000, as amended. Pub. L. No. 106-310, § 3101, 114 Stat. 1101, 1169-70 (codified as amended at 42 U.S.C. § 290hh-1). According to SAMHSA officials, funding opportunities have been issued in six cohorts since 2001. Fiscal year 2016 grant awards are currently under review. Through this initiative, SAMHSA created the National Child Traumatic Stress Network, a collaborative network of service providers, family and youth representatives, and researchers.

Health Care Quality Reporting Measures

SAMHSA initiated an online and television campaign to inform the public about efforts to treat child trauma and resources available through the National Child Traumatic Stress Initiative. SAMHSA has also formed a relatively new partnership with the National Center for Trauma-informed Care to develop coordinated networks focused on treatments shown to be effective in treating mental health conditions. In addition, SAMHSA has provided funding for webinars⁸⁸ and a national technical assistance program that supports research and training centers focused on trauma.⁸⁹

CMS added a measure on the use of multiple antipsychotic medications to the 2016 Core Set of Children's Health Care Quality Measures for Medicaid and the State Children's Health Insurance Program.⁹⁰ The core set is a voluntary set of measures that states may use to monitor and improve the quality of health care delivery to children covered under Medicaid, including those in foster care. In addition to the measure added by CMS, other measures related to children's use of antipsychotic medications include behavioral or mental health counseling services and metabolic monitoring.⁹¹ Through its group on antipsychotic medication use in children, CMS facilitates information sharing and provides technical assistance to help eight state Medicaid agencies improve their evaluations of state programs through the voluntary use of these measures. This will be the first year that states may voluntarily report on the measure for the use of multiple antipsychotic medications at the same time among children and adolescents. According to CMS officials, they provided a technical assistance webinar in August 2016 to help states determine how to measure this information. CMS officials said that a key CMS goal is to encourage and support national reporting by state

⁸⁸Webinar topics ranged from facilitating cross-system data sharing for medication oversight to telephonic psychiatric consultation models.

⁸⁹The Portland State University Pathways Research and Training Center publishes *Focal Point*. In 2015, an entire issue of *Focal Point* focused on trauma, including articles on the impact of trauma, implementation issues around trauma-informed care, organizational culture and policies, and evidence-based practices. *Focal Point: Youth, Young Adults, & Mental Health, Trauma-Informed Care, 2015, v.29* (Portland, OR: Research and Training Center for Pathways to Positive Futures, Portland State University).

⁹⁰The Children's Health Insurance Program Reauthorization Act of 2009 required HHS to identify and publish a core set of children's health care quality measures for voluntary use by state Medicaid and Children's Health Insurance programs, and beginning in January 2013, to annually publish recommended changes to the core measures. Pub. L. No. 111-3, § 401(a), 123 Stat. 8, 72-82 (codified as amended at 42 U.S.C. § 1320b-9a).

⁹¹These three measures are in the Healthcare Effectiveness Data and Information Set (HEDIS) for quality monitoring.

Medicaid agencies on a uniform set of measures to facilitate assessment of quality of care.⁹²

Officials from most of the seven selected states we reviewed said they use or plan to use some or all of these measures. For example, in February 2017 California's Medicaid agency will report to CMS measures on ADHD medication use and the use of multiple antipsychotic medications at the same time, among other things. The measures will include data on all children covered under their fee-for-service, managed care, and specialty mental health programs. In Ohio, state officials said they will build into managed care contracts two Healthcare Effectiveness Data and Information Set (HEDIS) measures as an oversight mechanism: the use of multiple antipsychotics at the same time in children and the first line psychosocial care for children and adolescents on antipsychotics.

HHS Has Supported Some State Collaboration on Medication Oversight, and Selected States Said More Federal Assistance Would Help

Although HHS has a variety of efforts to assist states in overseeing psychotropic medication use among children, since 2014 the agency has not convened meetings with all the relevant stakeholder groups needed to share information and work together on these issues. Under title IV-B of the Social Security Act, states are required to develop their plans for oversight and coordination of health care services for children in foster care in collaboration with the state Medicaid agency, and in consultation with pediatricians, experts in health care, and experts in and recipients of child welfare services.⁹³ HHS's guidance on implementing this provision and overseeing psychotropic medication use notes that state oversight should include coordination among and mechanisms to actively engage with child welfare, Medicaid, and mental health stakeholders to improve outcomes for this population.⁹⁴ This guidance also discussed HHS's goal of facilitating cross-system collaborations for the purposes of promoting

⁹²We previously reported that the core set of measures for children's health care quality are voluntarily reported by states and provide CMS with information on whether children are receiving needed care. Although the numbers of states reporting these measures had increased in recent years, states varied considerably in the number of measures they reported. We noted that CMS's ability to monitor children's access to services is dependent on consistent, reliable, complete, and sufficiently detailed data from each state. GAO, *Medicaid: Key Issues Facing the Program*, [GAO-15-677](#) (Washington, D.C.: July 30, 2015).

⁹³42 U.S.C. § 622(b)(15).

⁹⁴Administration for Children and Families, Information Memorandum, ACYF-CB-IM-12-03.

improved behavioral health diagnosis, treatment, service delivery, and service tracking for children in foster care, which includes actions to increase oversight and monitoring of psychotropic medications. However, HHS's assistance to states around collaboration has generally focused on a limited number of states or certain stakeholder groups. For example, SAMHSA hosted a day-long technical assistance meeting in 2015 for states with the capacity and commitment to implement improved cross-agency oversight of medication use, however, the meeting was limited to five states.⁹⁵ In addition, at its August 2016 National Conference on Child Abuse and Neglect, HHS held a breakout session which focused on a range of issues, including evaluation and oversight of medication, and how effective psychotropic medication oversight systems work in concert with efforts to ensure access to effective psychosocial services.⁹⁶ While the conference included this session, ACF officials said it was limited in scope compared to previous events it hosted on this issue.

ACF also finalized regulations in June 2016 that established requirements for a new, optional comprehensive child welfare information system that states can use to maintain their child welfare data.⁹⁷ If a state chooses to develop one, the new information system is required to support data exchanges with specified other systems, including Medicaid, court, and education systems, among other requirements. In the final rule, ACF stated that the new information system will provide child welfare agencies with the tools and flexibility to rapidly share data among multiple programs, including Medicaid and mental health. As discussed earlier, officials from child welfare and Medicaid agencies in most of the selected states spoke of challenges related to concerns about state and federal laws protecting individuals' privacy. In 2013, we reported that state and local human services agencies, among others surveyed, identified

⁹⁵These five states included Delaware, Hawaii, Kentucky, Mississippi, and Washington. States were selected based on a competitive application process that required articulation of existing goals related to medication oversight that would be advanced by participation in the technical assistance meeting. According to SAMHSA officials, they are planning follow-up with these states to assess their progress and develop training materials based on lessons learned and other resources.

⁹⁶The 20th National Conference on Child Abuse and Neglect in August 2016 included a variety of sessions over a 3-day period. Sessions focused on five core topic areas: promoting child and family well-being, shaping the workforce, building on strengths, leveraging community assets, and partnering for impact.

⁹⁷Comprehensive Child Welfare Information System, 81 Fed. Reg. 35,450 (June 2, 2016). The final rule went into effect on August 1, 2016, but provides for a 24-month transition period.

challenges related to the interpretation of federal privacy requirements as they balance the need to protect clients' personal information while increasing the use of data sharing.⁹⁸ These challenges included confusion or misperceptions about what agencies are allowed to share as well as a tendency to be risk averse and overly cautious in their interpretation of federal privacy requirements. ACF officials told us some states interpret federal laws on protecting confidentiality to have barriers when there often are not barriers at the federal level. They added that they have used their confidentiality toolkit to debunk myths and concerns with data sharing, though child welfare officials we interviewed in a few of the selected states said they were not aware of a federal toolkit on data sharing.⁹⁹

State officials in all seven selected states spoke of the importance of collaboration, and some said successful cross-agency collaboration has helped them oversee the use of psychotropic medications more effectively. Further, officials in most of these states said they benefitted from HHS's national convening in August 2012 of state directors of child welfare, Medicaid, and mental health agencies to address the use of psychotropic medications for children in foster care and their mental health needs. The meeting ("Because Minds Matter"), hosted by ACF, CMS, and SAMHSA, provided an opportunity for state leaders to enhance their collaboration on the appropriate use of psychotropic medications. Officials we spoke with said it helped them develop prescribing guidelines and expand reporting on psychotropic medications. According to officials in one selected state, their child welfare agency worked with its mental health agency partner at the HHS meeting to develop its informed consent process. Likewise, the meeting was the impetus for another selected state's child welfare and Medicaid agency partnership and its quality improvement project, according to state officials. This project involved engaging with multiple stakeholders throughout the state, forming work groups to study psychotropic medication use, and developing training materials and guidance on the proper use of these medications. In a third selected state, three lead agency directors and medical directors formed a team to provide clinical oversight of their foster care population. In addition, officials in one selected state said their participation in the meeting, and in other collaborative efforts, helped

⁹⁸[GAO-13-106](#).

⁹⁹As discussed earlier, HHS published a "Confidentiality Toolkit" in August 2014 that aims to support state and local data sharing efforts by bringing greater clarity to the rules governing confidentiality in certain human services programs.

them learn about the work of other states in effective monitoring of mental health care for children in foster care, including an improved ability to monitor medication use.

State officials in three of the seven selected states said more federal government leadership could help them work through ongoing challenges, including (1) obtaining best practices in medication use concurrent with other treatments; (2) overcoming siloes across child welfare, Medicaid, and mental health systems serving the foster care population; and (3) enhancing access to child and adolescent psychiatric resources. In addition, officials in selected states transitioning their foster care populations into managed care expressed concern about the transition, and the need to manage the transition to ensure optimal care coordination. Some of the concerns identified include (1) ensuring state agencies share data with the managed care providers to facilitate continuity of care, (2) bringing all the necessary stakeholders onboard during the transition to ensure a common understanding of concepts and roles, and (3) ensuring managed care plans have the needed tools to accommodate non-traditionally served populations that have high medical needs.¹⁰⁰

State child welfare, Medicaid, and mental health officials in three selected states said having other events similar to the one hosted by HHS in 2012 could provide further support in addressing these challenges. While ACF, CMS, and SAMHSA have held various events with limited numbers of states or certain stakeholder groups, as mentioned above, they have not convened a 50-state meeting that includes child welfare, Medicaid, and mental health stakeholders since 2012 to continue discussions about how best to oversee psychotropic medications. ACF officials said they have no plans to hold a national convening of state agency stakeholders. They explained that, in response to recent mandates on efficient government,

¹⁰⁰Our 2014 report on monitoring of psychotropic medications described similar transitions to managed care and limited planning among the states included in its review. [GAO-14-362](#). We recommended HHS issue guidance to help states implement oversight strategies within a managed care environment. CMS officials said they were continuing to provide guidance to states through their working group on antipsychotic medications for children, which includes states that provide prescription drug benefits through a managed care delivery system. However, this effort reaches a select number of states and focuses on antipsychotic medications rather than the broader classes of psychotropic medications. As of December 2016, the recommendation remained open.

they have moved toward hosting more virtual meetings.¹⁰¹ While virtual meetings can be a useful and cost-effective tool in facilitating collaboration and information sharing, none of HHS's virtual meetings on psychotropic medications have included most states and stakeholders across multiple services. HHS noted in its 2012 guidance to states on oversight of psychotropic medications that children in foster care are typically involved in multiple service delivery systems, and a coordinated, multi-system approach is necessary to meaningfully improve outcomes for this population. Additional efforts from HHS to include relevant stakeholders in collaborations to address continuing challenges can better position states in their work to improve practices to oversee medication use and effectively ensure appropriate treatments for the foster care population.

Conclusions

Though the benefits of using psychotropic medications have been documented, the health risks or side effects associated with certain prescribing patterns—such as the use of multiple psychotropic medications at the same time and the use of antipsychotics—make it important to ensure that a given treatment is appropriate for addressing a child's condition. State agencies in our seven selected states have taken steps to curb inappropriate prescriptions of psychotropic medications among children in foster care, often by collaborating with each other and with other stakeholders involved in the child's care. Officials in these states credited HHS with helping them jumpstart or further their efforts by fostering collaboration and providing forums to share information at HHS's 2012 conference.

While the states included in our review have made efforts to improve medication oversight, selected state officials and their partners discussed a need for continued collaboration and information sharing to help effectively implement oversight practices, improve access to mental health services, share data, and monitor outcomes. Information on oversight practices can be especially important for states that may not be as far along in their efforts to oversee medication use as those selected

¹⁰¹Specifically, officials pointed to: (1) Executive Order 13589, Promoting Efficient Spending, 76 Fed. Reg. 70,863 (Nov. 15, 2011) and OMB Memorandum M-12-12; (2) Executive Order 13576, Delivering Efficient, Effective, and Accountable Government, 76 Fed. Reg. 35,297 (June 16, 2011) and OMB Memoranda M-11-35; and (3) division E, title VII, sections 739 and division G, title V, section 527 of the Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, 128 Stat. 2130 (2014).

for this review, or for those experiencing a period of change as they transition their foster care populations into managed care. While HHS has made efforts to help support states in their oversight activities, additional support from HHS to convene state child welfare and Medicaid agencies and other stakeholders could create opportunities for state agencies to learn from one another's experience, collaboratively develop solutions to mitigate common challenges, strengthen oversight practices for psychotropic medications, and more effectively ensure appropriate treatments for children in foster care.

Recommendation for Executive Action

To help states effectively address ongoing challenges related to ensuring the appropriate use of psychotropic medications for children in foster care, the Secretary of HHS should consider cost-effective ways to convene state child welfare, Medicaid, and other stakeholders to promote collaboration and information sharing within and across states on psychotropic medication oversight.

Agency Comments and Our Evaluation

We provided a draft of this report to the Secretary of HHS for review and comment. HHS agreed with our recommendation and provided some examples of a virtual convening of select groups of professionals and agencies it employed to facilitate information sharing and collaboration around different issues. We believe that convening child welfare, Medicaid, and mental health stakeholders across all 50 states, in virtual or other settings, is an important step towards helping these stakeholders ensure the appropriate use of psychotropic medications for children in foster care. HHS also provided additional information on their efforts to date to help states address medical and mental health care for children in foster care. Finally, HHS provided technical comments, which we incorporated as appropriate. A letter conveying HHS's formal comments is reproduced in appendix III.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of HHS and interested congressional committees. The report will also be available at no charge on the GAO website at www.gao.gov.

If you or your staffs have any questions about this report, please contact me at (202) 512-7215 or Brownke@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on

the last page of this report. GAO staff who made key contributions to this report are listed in appendix IV.

Sincerely yours,

Kay E. Brown

Kay E. Brown, Director
Education, Workforce, and Income Security Issues

Appendix I: Objectives, Scope, and Methodology

This appendix discusses in detail our methodology for addressing three research questions: (1) how child welfare and Medicaid agencies in selected states work to ensure the appropriate use of psychotropic medications for children in foster care; (2) what is known about the results of their efforts, and (3) the extent to which the Department of Health and Human Services (HHS) helps states support the appropriate use of psychotropic medications for children in foster care. To address these questions, we reviewed relevant federal laws, regulations, and guidance. We interviewed HHS officials, and state officials in seven selected states and county officials in two of those states as well as officials in nine national professional and research organizations. We reviewed national, state, and county guidance and other documents identified by our interview subjects, and analyzed available data from selected states on medication use in foster care over a 5-year period.

To address all objectives, we conducted in-person and telephone interviews with officials in seven selected states, including officials from child welfare and Medicaid agencies and other partners, and with nine national child welfare, Medicaid, and mental health professional and research organizations.¹ The states we selected were Arizona, California, Illinois, Maryland, New Jersey, Ohio, and Washington. Our selection criteria included: (1) a high percentage of children in foster care and congregate care in the state when compared nationwide in fiscal year 2014; (2) variation in the type of Medicaid delivery system covering psychotropic medications and other mental health services for children in foster care (i.e., fee-for-service versus single or multiple managed care organizations)² and in the type of child welfare system (i.e., state- versus county-administered);³ (3) recommendations from national organizations

¹We interviewed additional stakeholders when referred to us by officials from the selected state child welfare and Medicaid agencies. Examples of additional stakeholders include state or county mental health agency officials, employees of partnering universities, and a state child welfare agency advisory committee made up of former foster youth.

²Of our seven selected states, three states—Illinois, Maryland, and Ohio—use a fee-for-service system to deliver psychotropic medications and mental health services to children in foster care on Medicaid. Of the remaining four states, Arizona uses multiple managed care organizations to deliver these services, California may deliver these services under fee-for-service or managed care depending on the county, New Jersey uses multiple organizations to deliver psychotropic medications and a fee-for-service system for other mental health services, and Washington transitioned the delivery of these services from a fee-for-service system to a single managed care organization as of April 1, 2016.

³Of our seven selected states, five states have state-administered child welfare systems (Arizona, Illinois, Maryland, New Jersey, and Washington) and two have county-administered systems (California and Ohio).

we interviewed for states that have or are in the process of implementing practices to oversee and monitor psychotropic medications; and (4) diversity in geographic location. In two states with county-administered child welfare systems, California and Ohio, we selected five counties and conducted interviews with officials from the respective county-level child welfare and Medicaid agencies, as appropriate.⁴ These counties were selected based on factors similar to those mentioned above as well as variation in population density (i.e., rural versus urban). Our findings cannot be generalized to states or counties outside our selection sample.

In the report we use qualifiers, such as “a few,” “some,” and “most” to quantify responses from officials across our interviews with state and county child welfare and Medicaid agencies and their partners, such as universities and state or county mental health agencies. We reported the total number of the seven selected states in which at least one official or partner gave the reported response. These qualifiers are defined as follows:

- “All” states represents seven
- “Most” states represents five to six
- “Some” states represents three to four
- “A few” states represents two

We interviewed representatives from nine national professional and research organizations selected to represent a variety of views on child welfare, Medicaid, and mental health-related policy and research. These organizations were: American Academy of Child & Adolescent Psychiatry, American Academy of Pediatrics, Center for Health Care Strategies, Child Welfare League of America, Medicaid and CHIP Payment and Access Commission, National Association of Medicaid Directors, National Association of Public Child Welfare Administrators, National Association of State Mental Health Program Directors, and National Alliance on Mental Illness.

For all our interviews, we used a semi-structured interview protocol that included open-ended questions about state child welfare and Medicaid delivery systems; state and county oversight practices, including related challenges and measurement of outcomes; and federal efforts to assist

⁴The counties we selected are Fairfield, Lucas, and Perry counties in Ohio, and Los Angeles and Sonoma counties in California.

states. Information was volunteered by officials in each interview in response to these open-ended questions. Thus, the counts of organizations citing such responses vary. We reviewed relevant documents to corroborate information obtained in our interviews, when possible.

To examine how state child welfare and Medicaid agencies work to ensure the appropriate use of psychotropic medications, we also reviewed guidance and other documents identified by officials from selected states and counties.⁵ While we identified selected states' oversight and monitoring practices related to psychotropic medications based on interviews and these document reviews, we did not assess the effectiveness of states' implementation of these practices, nor did we evaluate their compliance with state or federal requirements or whether there are controls in place to help ensure that required practices are followed. In addition, while we focused our review on children in foster care, state oversight practices may also pertain to other children on Medicaid. We also reviewed guidance on oversight and monitoring of psychotropic medications for children issued by national health care professional organizations.⁶ In addition, we reached out to selected states' audit agencies and HHS's Office of Inspector General to identify past, ongoing, or planned work in this area. We also conducted a review of selected literature, including reports from academic, professional, and governmental organizations, related to the use of psychotropic medications and published since GAO's report in April 2014.⁷

To examine the results of state efforts to ensure the appropriate use of psychotropic medications, we gathered and analyzed available data from selected states on the use of these medications among children in foster care from 2011 through 2015.⁸ We selected this range in order to gather data on 5-year trends that included the most recent data available. To examine the reliability of these data, we interviewed and sent a

⁵We did not conduct a review of state laws and regulations.

⁶For example, we reviewed AACAP's 2015 *Recommendations about the Use of Psychotropic Medications for Children and Adolescents Involved in Child-Serving Systems*, among other documents.

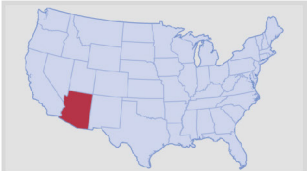
⁷[GAO-14-362](#).

⁸We analyzed data for six of our seven selected states. The remaining state—Ohio—was unable to provide data from 2011 through 2015; Ohio child welfare officials said they did not collect data on the use of medications in the past, but began to do so as of May 2016.

questionnaire to relevant state child welfare and Medicaid officials and examined the data received to identify any obvious outliers. We determined that these data were sufficiently reliable for the purposes of describing trends in the percentage of children in foster care on psychotropic medications for each of the selected states. However, because these states use different methodologies to collect data (e.g., states collected data for different time periods and ages of children in foster care), the data are not comparable among them. In addition, the results of our analyses are not generalizable nationwide. Information collected from selected states, such as on their oversight practices and measures collected to examine the results of their efforts, was provided to officials in each selected state for their review and verification.

To examine HHS's actions to support state efforts related to psychotropic medications, we interviewed officials from the Administration for Children and Families, Centers for Medicare & Medicaid Services, and Substance Abuse and Mental Health Services Administration, and reviewed relevant documents. In addition, we reviewed guidance on oversight and monitoring of psychotropic medications for children issued by HHS and used it as criteria for our recommendation.

Appendix II: Selected State Information



Arizona

State characteristics

Number of children in foster care: 16,246

Source: GAO analysis of Health and Human Services data as of September 30, 2014, the most recent data available.

Child welfare administration system:
State-administered

Medicaid delivery system for psychotropic medications and other mental health services for children in foster care: Managed care under multiple managed care organizations, collectively called Regional Behavioral Health Authorities

Source: GAO analysis of state-level information or documents collected from state officials in selected states.

State agencies involved

Oversight practices and implementation: Generally required by state laws or required/recommended by state regulations, child welfare or Medicaid agency policies, or guidelines, and implemented by the following state agencies or other stakeholders:

- Arizona Health Care Cost Containment System
- Department of Child Safety
- Department of Health Services' Division of Behavioral Health Services

Source: GAO analysis of state-level information or documents collected from state officials in selected states.

Oversight practices

Practices to improve the prescribing process

- Required mental health screening of the child by physicians within 72 hours of entering foster care and follow-up mental health assessment within 7 days when indicated.
- For children ages 0 to 5: guidelines to address the use of medications and recommended use of medications only after psychosocial services have been tried; recommended restrictions on who can prescribe; and required specialist review when a non-specialist prescribes. For all children in foster care: required specialist review of some prescriptions.
- Agreement for the prescription required from an adult (e.g., child welfare official or caregiver) and recommended from the child (physician must document agreement).
- Monitoring of the child required through physician visits and reviews or reauthorizations of some prescriptions.

Practices to increase stakeholders' mental health knowledge

- Trainings on trauma-informed care; connecting patients with off-site specialists through remote consultation services.

Source: GAO analysis of state-level information or documents collected from state officials in selected states.

Note: For this review, we did not evaluate the effectiveness of states' or counties' implementation of specific practices, their compliance with state or federal requirements, or whether there are controls in place to ensure that required practices are followed.

Measures used to gauge state's results

Arizona has conducted two reviews of psychotropic medication use among children in foster care. Measures collected include:

- **Physician prescribing patterns:** The state examined the number of children who took any medications, two or more medications at the same time, certain classes of medications such as antipsychotics, and dosage levels.
- **State oversight practices:** The state examined the number of children who received a mental health assessment, received psychosocial services, and were prescribed medications in dosages exceeding certain prescribing guidelines. The state also examined standardized health care quality measures, including physician follow-up after a child is prescribed attention deficit hyperactivity disorder (ADHD) medications.
- **Child outcomes:** The state examines information on placement disruptions and health outcomes (e.g., emergency room visits) for children in foster care, including those on psychotropic medications.

Source: GAO analysis of state-level information or documents collected from state officials in selected states.

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Arizona



California

State characteristics

Number of children in foster care: 56,771

Source: GAO analysis of Health and Human Services data as of September 30, 2014, the most recent data available.

Child welfare administration system:
County-administered

Medicaid delivery system for psychotropic medications and other mental health services for children in foster care: Can be fee-for-service or managed care under single or multiple managed care organizations, depending on the county

Source: GAO analysis of state-level information or documents collected from state officials in selected states.

View [GAO-17-129](#). For more information, contact Kay E. Brown at (202) 512-7215 or brownke@gao.gov.

State agencies involved

Oversight practices: Generally required by state laws or required/recommended by state regulations, guidance, or policies from the following state agencies:

- Department of Social Services
- Department of Health Care Services

Implementation: Generally by county agencies or other stakeholders.

Source: GAO analysis of state-level information or documents collected from state officials in selected states.

Oversight practices

Practices to improve the prescribing process

- Required mental health screening of the child managed by county child welfare agencies.
- Guidelines to address the use of medications, including safety, monitoring, and selection of treatments; recommended restrictions on who can prescribe; recommended use of psychosocial services prior to medications for some mental health conditions and concurrently with medications for all conditions; and required review of antipsychotics prior to dispensing medication, managed by county Medicaid agencies.
- Agreement for the prescription required from the county juvenile court through documented consent and recommended from the child, when able (courts may delegate consent authority to the child's parents).
- Monitoring of the child by county courts through required reauthorization of the prescription in cases where the court retains its authority to consent.

Practices to increase stakeholders' mental health knowledge

- Trainings and informational materials on the proper use of medications, mental health treatments, trauma-informed care, children's rights, best practices for physicians, and lists of questions that youth and caregivers can ask their physician, social worker, attorney or judge, and pharmacist.

Source: GAO analysis of state-level information or documents collected from state officials in selected states.

Note: For this review, we did not evaluate the effectiveness of states' or counties' implementation of specific practices, their compliance with state or federal requirements, or whether there are controls in place to ensure that required practices are followed.

Measures used to gauge state's results

While counties are primarily responsible for overseeing psychotropic medication use, the two state agencies have been working collaboratively on an agreement to share state data. Measures collected include:

- **Physician prescribing patterns:** The state examines, by county, quarterly reports on the number of children taking any medications, two or more medications at the same time, or antipsychotics.
- **State oversight practices:** The state examines whether a child on medications received a mental health assessment, is receiving psychosocial services, has documented consent for medications, had physician follow-up after a medication is prescribed, and had metabolic tests completed, for example, blood glucose if taking an antipsychotic.
- **Child outcomes:** The state has begun examining the number of children on medications who had placement disruptions as of October 2016, and may examine additional outcome measures in the future.

Source: GAO analysis of state-level information or documents collected from state officials in selected states.

California



State characteristics

Number of children in foster care: 17,140

Source: GAO analysis of Health and Human Services data as of September 30, 2014, the most recent data available.

Child welfare administration system: State-administered

Medicaid delivery system for psychotropic medications and other mental health services for children in foster care: Fee-for-service. The state started a pilot in February 2014, called the Choices Project, to coordinate health services provided under the fee-for-service model

Source: GAO analysis of state-level information or documents collected from state officials in selected states.

View [GAO-17-129](#). For more information, contact Kay E. Brown at (202) 512-7215 or brownke@gao.gov.

Illinois

State agencies involved

Oversight practices and implementation: Generally required by state laws or required/recommended by state regulations, child welfare or Medicaid agency policies, or guidance, and implemented by the following state agencies or other stakeholders:

- Department of Child and Family Services
- Department of Healthcare and Family Services

Source: GAO analysis of state-level information or documents collected from state officials in selected states.

Oversight practices

Practices to improve the prescribing process

- Required mental health screening of the child by child welfare officials within 55 days of entering foster care.
- Guidelines to address the use of medications, including classifications, safety, dosages, and monitoring; required restrictions on using medications to replace psychosocial services; and required specialist reviews of prescriptions, with required Medicaid officials' review of some prescriptions.
- Agreement for the prescription required from a child welfare official and from children ages 18 and above and recommended from children under 18 (physician must document agreement).
- Monitoring of the child by physicians required at least every 90 days, monthly written reviews of high risk children under 6 required and referrals to intensive case management, as needed, and required through renewed agreements for the prescription every 180 days.

Practices to increase stakeholders' mental health knowledge

- Trainings and informational materials about psychotropic medications and other treatments and children's mental health; and consultation resources for physicians.

Source: GAO analysis of state-level information or documents collected from state officials in selected states.

Note: For this review, we did not evaluate the effectiveness of states' or counties' implementation of specific practices, their compliance with state or federal requirements, or whether there are controls in place to ensure that required practices are followed.

Measures used to gauge state's results

State agencies partner with the University of Illinois at Chicago to oversee medication use and track state performance on oversight practices.

Measures collected include:

- **Physician prescribing patterns:** The state examines quarterly reports on the number of children taking any psychotropic medications and certain classes of medications, such as antipsychotics. It also examines reports on children under age 6 taking two or more medications at the same time and monitors prescribed dosage levels.
- **State oversight practices:** The state examines whether a child on medications is receiving psychosocial services, has documented consent for medications, and has received a mental health assessment (for children under 6). It also examines information on the child's metabolic health obtained from physicians and the number of physicians who prescribe outside of state prescribing guidelines.
- **Child outcomes:** The state examines the number of children under 6 that had placement disruptions, symptoms of self-harm, or had been hospitalized.

Source: GAO analysis of state-level information or documents collected from state officials in selected states.

Illinois



Maryland

State characteristics

Number of children in foster care: 4,032

Source: GAO analysis of Health and Human Services data as of September 30, 2014, the most recent data available.

Child welfare administration system: State-administered

Medicaid delivery system for psychotropic medications and other mental health services for children in foster care: Fee-for-service

Source: GAO analysis of state-level information or documents collected from state officials in selected states.

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State agencies involved

Oversight practices and implementation: Generally required by state laws or required/recommended by state regulations, child welfare or Medicaid agency policies, or guidance, and implemented by the following state agencies or other stakeholders:

- Department of Human Resources
- Department of Health and Mental Hygiene's Behavioral Health Administration and Health Care Financing Administration

Source: GAO analysis of state-level information or documents collected from state officials in selected states.

Oversight practices

Practices to improve the prescribing process

- Required mental health screening of the child by physicians within 60 days of entering foster care.
- Guidelines to address the use of medications, including safety and monitoring; guidelines prohibiting the use of medication as a substitute for psychosocial services; required specialist review of antipsychotics; and required consultation with a specialist when the prescribing physician is not a child psychiatrist.
- Agreement for the prescription required from an adult (e.g., parent) and from children ages 16 and above, when able (child welfare officials must document agreement).
- Monitoring of the child required at caseworkers' monthly home visits, required at physicians' visits, required through reauthorizations for children taking antipsychotics, and required through renewed agreements for the prescription annually.

Practices to increase stakeholders' mental health knowledge

- Outreach to physicians and parent-to-parent outreach program to educate stakeholders about mental health treatments and treatment availability; consultation resources for physicians; and connecting patients with off-site specialists through remote consultation services.

Source: GAO analysis of state-level information or documents collected from state officials in selected states.

Note: For this review, we did not evaluate the effectiveness of states' or counties' implementation of specific practices, their compliance with state or federal requirements, or whether there are controls in place to ensure that required practices are followed.

Measures used to gauge state's results

The two state agencies developed an agreement to share child welfare and Medicaid data with the University of Maryland School of Pharmacy, which matches the data and reports monthly information about children in foster care to these state agencies. Measures collected include:

- **Physician prescribing patterns:** The state examines the proportion of children taking any medications, certain classes of medications, certain combinations of medications, and dosage levels.
- **State oversight practices:** The state examines the number of children on antipsychotics who receive psychosocial services and information on their metabolic health, for example, glucose levels, obtained from physicians.
- **A child's health status and other outcomes:** The state examines the number of placement disruptions, the number of emergency room visits and hospitalizations, and information on a child's enrollment in school and academic performance (through an additional agreement with the state educational agency).

Source: GAO analysis of state-level information or documents collected from state officials in selected states.

Maryland



New Jersey

State characteristics

Number of children in foster care: 7,138

Source: GAO analysis of Health and Human Services data as of September 30, 2014, the most recent data available.

Child welfare administration system:
State-administered

Medicaid delivery system for psychotropic medications for children in foster care: Managed care under multiple managed care organizations

Medicaid delivery system for other mental health services:
Fee-for-service

Source: GAO analysis of state-level information or documents collected from state officials in selected states.

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State agencies involved

Oversight practices and implementation: Generally required by state laws or required/recommended by state regulations, child welfare or Medicaid agency policies, or guidance, and implemented by the following state agencies or other stakeholders:

- Department of Children and Families
- Department of Human Services, Division of Medical Assistance and Health Services

Source: GAO analysis of state-level information or documents collected from state officials in selected states.

Oversight practices

Practices to improve the prescribing process

- Required mental health screening of the child by nurses or physicians within 30 days of entry into foster care.
- Guidelines to address the use of medications, including classification, dosages, safety, and monitoring; required restrictions on who can prescribe; and recommended use of other treatments prior to medications and required use of psychosocial services concurrently with medications.
- Agreement for the prescription required from an adult (e.g., parent) and recommended from the child, when able (the child's health care case manager is primarily responsible for documenting agreement).
- Monitoring of the child by physicians required at least once a month until the child's dosage and effect have stabilized and at least once every 3 months thereafter; quarterly reviews of prescriptions by specialists to check for factors such as medication safety; and annual renewal of agreement for the prescription.

Practices to increase stakeholders' mental health knowledge and access to services

- Trainings on psychotropic medications and mental health conditions.

Source: GAO analysis of state-level information or documents collected from state officials in selected states.

Note: For this review, we did not evaluate the effectiveness of states' or counties' implementation of specific practices, their compliance with state or federal requirements, or whether there are controls in place to ensure that required practices are followed.

Measures used to gauge state's results

Assigned nurses serve as health care case managers for children in foster care. The nursing program provides quarterly reports to the Department of Child and Family Services and other officials for review. Measures collected include:

- **Physician prescribing patterns:** Nurses track the use of any medications and dosage levels. The state reviews the nursing program's quarterly reports to examine the appropriateness of medication use (e.g., cases in which children were prescribed two or more medications of the same class or three or more psychotropic medications at the same time).
- **State oversight practices:** Nurses track whether a child has had a mental health assessment, is receiving psychosocial services, has documented consent for medications, and is prescribed a medication by a physician with an approved specialty.

Source: GAO analysis of state-level information or documents collected from state officials in selected states.

New Jersey



Ohio

State characteristics

Number of children in foster care: 12,519

Source: GAO analysis of Health and Human Services data as of September 30, 2014, the most recent data available.

Child welfare administration system:
County-administered

Medicaid delivery system for psychotropic medications and other mental health services for children in foster care: Fee-for-service (with plans to transition to managed care in January 2017)

Source: GAO analysis of state-level information or documents collected from state officials in selected states.

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State agencies involved

Oversight practices: Generally required by state laws or required/recommended by state regulations, guidance, or policies from the following state agencies:

- Department of Job and Family Services
- Department of Medicaid
- Department of Mental Health and Addiction Services

Implementation: Generally by county agencies or other stakeholders.

Source: GAO analysis of state-level information or documents collected from state officials in selected states.

Oversight practices

Practices to improve the prescribing process

- Required mental health screening of the child within 60 days of entering foster care; requirement for counties to have policies on screening, assessment, and treatment.
- Guidelines to address the use of medications, including classification, dosages, side effects, safety, and monitoring; recommended use of psychosocial services prior to medications; restrictions on who can prescribe; and specialist consultation for prescribing outside of guidelines.
- Agreement for the prescription required from a child welfare official and recommended from a parent and from school-age children, when able.
- Monitoring of the child recommended through child welfare officials' monthly home visits and random reviews of prescriptions by specialists.

Practices to increase stakeholders' mental health knowledge and access to services

- Trainings and informational materials on psychotropic medications and other treatments, children's mental health, and tools to assist children and families in participating in treatment decisions; consultation resources for physicians; connecting patients with off-site specialists through remote consultation services; and support for residency programs in psychiatry, nursing, family medicine, and pediatrics.

Source: GAO analysis of state-level information or documents collected from state officials in selected states.

Note: For this review, we did not evaluate the effectiveness of states' or counties' implementation of specific practices, their compliance with state or federal requirements, or whether there are controls in place to ensure that required practices are followed.

Measures used to gauge state's results

The state conducted point-in-time studies on mental health services and on practices for overseeing medication use in selected county pilot sites for all children on Medicaid. Measures collected include:

- **Physician prescribing patterns:** The state examined the number of children (statewide) who took any medications. In pilot sites, the state examined the number of children who took four or more psychotropic or two or more antipsychotic medications at the same time, and the number of children under 6 who took any antipsychotics.
- **State oversight practices:** The state examined the number of children (statewide) who received psychosocial services. In pilot sites, the state examined the number of prescriptions made outside of state prescribing guidelines and the number of physicians who reported increased confidence and expertise in serving children with mental health conditions.

Source: GAO analysis of state-level information or documents collected from state officials in selected states.

Ohio



State characteristics

Number of children in foster care: 10,630

Source: GAO analysis of Health and Human Services data as of September 30, 2014, the most recent data available.

Child welfare administration system:
State-administered

Medicaid delivery system for psychotropic medications and other mental health services for children in foster care: Managed care under a single managed care organization called Apple Health Core Connections of Washington (newly transitioned from a fee-for-service system as of April 1, 2016)

(Note: Children with complex mental health needs are served by behavioral health organizations contracted with the state. State child welfare and Medicaid officials said these services will be integrated into managed care in 2018.)

Source: GAO analysis of state-level information or documents collected from state officials in selected states.

View [GAO-17-129](#). For more information, contact Kay E. Brown at (202) 512-7215 or brownke@gao.gov.

Washington

State agencies involved

Oversight practices and implementation: Generally required by state laws or required/recommended by state regulations, child welfare or Medicaid agency policies, or guidance, and implemented by the following state agencies or other stakeholders:

- Department of Social and Health Services, Children’s Administration and Behavioral Health Administration
- Health Care Authority

Source: GAO analysis of state-level information or documents collected from state officials in selected states.

Oversight practices

Practices to improve the prescribing process^a

- Required mental health screening of a child entering foster care for at least 30 days; child welfare staff are to screen child within 30 days of entry.
- Guidelines to classify psychotropic medications; recommended use of psychosocial services before medications; and required specialist consultation and Medicaid officials’ approval before filling some prescriptions.
- Agreement for the prescription required from an adult (e.g., parent) or from the child when ages 13 and above, when able.
- Monitoring of the child through rescreening after 6, 12, and 18 months; required at caseworkers’ monthly visits; and required through nurses’ case file reviews.

Practices to increase stakeholders’ mental health knowledge and access to services

- Trainings and informational materials on psychotropic medications and other mental health treatments, children’s mental health, children’s rights, and the child welfare system; consultation resources for physicians; and connecting patients with off-site specialists through remote consultation services.

Source: GAO analysis of state-level information or documents collected from state officials in selected states.

Note: For this review, we did not evaluate the effectiveness of states’ or counties’ implementation of specific practices, their compliance with state or federal requirements, or whether there are controls in place to ensure that required practices are followed.

^aOfficials said practices may change as Washington transitions to a managed care model.

Measures used to gauge state’s results

The state conducted point-in-time studies on medication use and continues to examine these data for certain populations of children.

Measures collected include:

- **Physician prescribing patterns:** The state examined the number of children who took any psychotropic or antipsychotic medications. The state also examines the number of children ages 3 to 17 taking four or more psychotropic medications at the same time and dosage levels for children ages 5 to 17.
- **State oversight practices:** The state examines the number of children who received a mental health assessment and psychosocial services (ages 3 to 17), number of prescriptions outside of state prescribing guidelines, and feedback from physicians on its consultation services.
- **Child outcomes:** The state examines the number of children who were hospitalized or were involved in the juvenile justice system (for children with mental health needs ages 3 to 17).

Source: GAO analysis of state-level information or documents collected from state officials in selected states.

Washington

Appendix III: Agency Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

DEC 19 2016

Kay Brown
Director, Education, Workforce, and Income Security Issues
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Brown:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*Foster Care: HHS Has Taken Steps to Support States' Oversight of Psychotropic Medications, but Additional Assistance Could Help Further Collaboration*" (GAO-17-129).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

A handwritten signature in cursive script that reads "Jim R. Esquea".

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: FOSTER CARE: HHS HAS TAKEN STEPS TO SUPPORT STATES' OVERSIGHT OF PSYCHOTROPIC MEDICATIONS, BUT ADDITIONAL ASSISTANCE COULD HELP FURTHER COLLABORATION (GAO-17-129)

The U.S. Department of Health and Human Services (HHS) appreciates the opportunity from the Government Accountability Office (GAO) to review and comment on this draft report.

Recommendation

To help states effectively address ongoing challenges related to ensuring the appropriate use of psychotropic medications, HHS should consider cost-effective ways to convene state child welfare, Medicaid, and other stakeholders to promote collaboration and information sharing within and across states.

HHS Response

HHS concurs with GAO's recommendation. GAO's recommendation is consistent with HHS's current efforts to provide high quality, high impact technical assistance through electronic medium to ensure effective use of tax payer dollars. We offer a couple of examples of the virtual convening employed to provide technical assistance and peer to peer networking in child welfare:

The Child Welfare Virtual Expo: Building Capacity to Address Sex Trafficking and Normalcy (Virtual Expo), held on July 13, 2016, represented a new approach to building capacity among child welfare professionals. Hosted by the Capacity Building Center for States (the Center) in partnership with the Children's Bureau (CB), the Virtual Expo showcased the use of technology for engagement, information sharing, and making connections.

As a result of targeted promotion through email, listservs, and social media channels, more than 1,050 individuals from 57 jurisdictions (States or territories) registered for the Virtual Expo and have access to related materials. More than 550 attendees logged in and an estimated 750 people participated in the live event, accounting for groups that watched the event together. The Virtual Expo reached many people who might not have been able to attend an in-person conference because of travel restrictions, costs, or time away from the office. About half of the registered attendees were from a child welfare agency, and about one-quarter were program/middle managers.

Through the online platform, participants were provided with opportunities for online networking with subject matter experts and peers and for accessing a wide array of resources to support their work related to sex trafficking and normalcy. Attendees reported high satisfaction with Virtual Expo content and most session survey respondents (94–96 percent) would recommend the recorded sessions to colleagues. As a result of participation, 80 percent of respondents were aware of available resources, tools, and capacity building services to access and apply in their work. Additional participants continue to access the archived learning experience.

Constituency Groups: The Capacity Building Center for States' Constituency Services create opportunities for cohorts of child welfare professional and groups of child welfare agencies to establish collaborative networks, connect with peers facing similar challenges, and discuss and share resources, information, and ideas. Through Constituency Services, the Center builds

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: FOSTER CARE: HHS HAS TAKEN STEPS TO SUPPORT STATES' OVERSIGHT OF PSYCHOTROPIC MEDICATIONS, BUT ADDITIONAL ASSISTANCE COULD HELP FURTHER COLLABORATION (GAO-17-129)

relationships and connects child welfare professionals through peer networks called Constituency Groups. Constituency Groups come in many shapes and sizes and may take the following forms:

- Child welfare professional groups (e.g., State foster care managers)
- Public child welfare agency cohorts (e.g., county-administered systems)
- Title IV-E waiver demonstration cohorts
- Specific partnerships (e.g., State-Tribe, agency-court)
- Topical groups (e.g., implementers of P.L. 113-183)

These groups engage in peer networking through the use of listserves and other technology to communicate ideas, events and services relevant to the group.

Attached is more information on the types of technical assistance that has been offered and is planned specifically as it relates to the topic of mental health and psychotropic medication.

Appendix IV: Staff Acknowledgments

GAO Contact

Kay E. Brown, (202) 512-7215 or brownke@gao.gov

Staff Acknowledgments

In addition to the contact named above, Elizabeth Morrison (Assistant Director), Claudine Pauselli (Analyst-in-Charge), Linda Collins, and Nhi Nguyen made key contributions to this report. Also contributing to this report were Seto Bagdoyan, James Bennett, David Chrisinger, Sarah Cornetto, Celina Davidson, Sara Edmondson, Sandra George, Katherine Iritani, Angie Jacobs, Kirsten Lauber, Hannah Locke, Sheila McCoy, Jonathan McMurray, and Jennifer Whitworth.

Related GAO Products

Foster Children: HHS Could Provide Additional Guidance to States Regarding Psychotropic Medications. [GAO-14-651T](#). Washington, D.C.: May 29, 2014.

Foster Children: Additional Federal Guidance Could Help States Better Plan for Oversight of Psychotropic Medications Administered by Managed-Care Organizations. [GAO-14-362](#). Washington, D.C.: April 28, 2014.

Children's Mental Health: Concerns Remain about Appropriate Services for Children in Medicaid and Foster Care. [GAO-13-15](#). Washington, D.C.: December 10, 2012.

Foster Children: HHS Guidance Could Help States Improve Oversight of Psychotropic Prescriptions. [GAO-12-201](#). Washington, D.C.: December 14, 2011.

Foster Children: HHS Guidance Could Help States Improve Oversight of Psychotropic Prescriptions. [GAO-12-270T](#). Washington, D.C.: December 1, 2011.

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