COUNTY OF LOS ANGELES
OFFICE OF CHILD PROTECTION

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JUDGE MICHAEL NASH (RET.)
EXECUTIVE DIRECTOR

August 20, 2018

To: Supervisor Sheila Kuehl, Chair
Supervisor Hilda L. Solis
Supervisor Mark Ridley-Thomas
Supervisor Janice Hahn
Supervisor Kathryn Barger

From: Judge Michael Nash (Ret.)
Executive Director, Office of Child Protection

PSYCHOTROPIC MEDICATION—YOUTH ENGAGEMENT AND TRANSITION-AGE YOUTH (TAY)

On August 22, 2017, the Board directed the Chief Executive Officer (CEO), in conjunction with the Executive Director of the Office of Child Protection (OCP), to coordinate with relevant County Departments and others "to coalesce existing efforts as the basis for a cohesive multi-year Countywide strategy that will support the self-sufficiency goals of TAY at the earliest stage possible . . . " The CEO has filed its response to the Board's motion. This memo is one of two adjunct memos to be filed by the OCP on important topics relevant to the Board's directive.

Each year, hundreds of youth in foster care under the care, custody, and control of both the Department of Children and Family Services (DCFS) and the Probation Department reach the age of 18. At that time, they either enter extended foster care or have their cases terminated.

Many of these youth are and have been taking psychotropic medications. When they reach age 18, they must be prepared to decide whether or not to continue and maintain their medication regimen.

In November 2017, Chapin Hall at the University of Chicago issued a brief titled, "The Use of Psychotropic Medications Over Time Among Foster Youth Transitioning to Adulthood" (Attachment 1). In that brief, the authors noted the need for oversight, stating:

> *Through the Child and Family Services Improvement Act of 2006, the U.S. Congress mandated state child welfare agencies to develop plans to monitor the use of psychotropic medications administered to children in state care.*

The authors further noted:

> *In California, the state with the largest foster youth population in the U.S., three Senate bills (SB 238, SB 484, and SB 1174) were enacted in 2015 and 2016 to improve oversight of psychotropic medication use among children in foster care . . . "*

At the end of the brief, the authors made the following important statement:

> *Professionals in the child welfare and mental health fields need to be prepared to engage foster youth in conversations that will increase youths' competency and comfort with making decisions about addressing their behavioral health issues.*

In 2012, the National Council of Juvenile and Family Court Judges (NCJFCJ) issued a resolution titled, "Resolution Regarding Judicial Oversight of Psychotropic Medications for Children Under Court Jurisdiction" (Attachment 2). In that resolution, the NDJFCJ stated:

> *WHEREAS, the NCJFCJ believes that judicial oversight means, at a minimum, that each court:*
>
> . . .
>
> - *Ensures children have been engaged at the earliest possible time in the medication process, allowing the court to have an understanding of their attitude toward medications and whether additional services or resources will be necessary to assure mediation compliance.*
>
> - *Ensures all children transitioning from child welfare or juvenile justice who are being administered psychotropic medications have been educated sufficiently to maintain their medication regimen and make decisions about their care, including possible adverse effects of sudden discontinuation of psychotropic medications.*

The resolution went on to resolve:

> *NCJFCJ shall promote the exercise of judicial leadership to convene and engage states and other jurisdictions, communities, and stakeholders in the child welfare and juvenile justice systems in meaningful partnerships to encourage and ensure, when necessary, the appropriate use of psychotropic medications for children and youth under court jurisdiction.*

To engage and prepare youth who turn 18 to be able to decide whether or not to continue their psychotropic medication regimen and to maintain their medication regimen if they so decide, requires an effort from all individuals and entities involved with them. These individuals and entities include caregivers, prescribing physicians, public health nurses, social workers, probation officers, Court-Appointed Special Advocate (CASA) volunteers, attorneys, and judicial officers.

This memo lists some systematic approaches to youth engagement that should help meet these goals. While overlap clearly exists between the two systems (child welfare and juvenile justice), the two are discussed separately. The following pages attempt to incorporate what has often been referred to as the involvement of the "whole village"[1] in our approach to the use of psychotropic medication on our system-involved youth.

Youth in the Child Welfare System

1. First on the list are the Judicial Council forms. The new forms were designed to engage the children and youth as well as other stakeholders.

JV-220–Application for Psychotropic Medication This form, completed by the social worker, includes information from the child and the caregiver, and provides an ongoing mechanism to receive input from the child.
JV-220(A)–Physician's Statement This form requires the physician to provide information to the child in an age-appropriate manner, and requires the physician to note the child's response.
JV-218–Child's Opinion About the Medicine This form was specifically devised to directly receive input from the child.
JV-219–Statement About Medication Prescribed **JV-222–Input on Application for Psychotropic Medication** These forms provide an opportunity for caregivers, parents, teachers, CASAs, attorneys, and others to provide information about the use of the medication.
JV-224–County Report on Psychotropic Medication This form, which is used for all progress reports and status-review hearings, specifically requests input from the child.

2. The second mechanism is DCFS' Health & Medication Guide (Attachment 3), which lays out milestones to be achieved in engaging and preparing youth to handle their medication needs, and the role of social workers vis-à-vis caregivers, health and mental health providers, public health nurses, and others in helping youth achieve those milestones.

[1] The "whole village" consists of the members of the Psychotropic Medication Workgroup, which includes DCFS, Probation, the Department of Public Health, the Department of Mental Health, the Public Defender, the Alternate Public Defender, Children's Law Center, Los Angeles Dependency Lawyers, Inc., County Counsel, California Youth Connection, the County's Commission for Children and Families, CASA Los Angeles, and the Juvenile Court.

It is recommended that DCFS adopt these guidelines, train social workers on them, and ultimately implement them.

DCFS endorses the concepts within this guide, which the department developed several years ago. Social workers currently access the guide through LA KIDS and the Department will use the guide in pertinent trainings.

3. The third mechanism is the Children's Law Center (CLC) memorandum of October 20, 2017, on "Policy Recommendations to Promote Medical Decision-Making Readiness—Revised" (Attachment 4). Consistent with the DCFS guidelines, this memo outlines the role of the child's attorney in working with others to achieve the various engagement and preparation milestones.

   We ask that CLC formally adopt and implement these recommendations.

4. The fourth mechanism is the use of a brochure created by the Children's Bureau of the Administration on Children, Youth and Families within the U.S. Department of Health and Human Services, *Making Healthy Choices: A Guide on Psychotropic Medications for Youth in Foster Care* (Attachment 5).

   Beginning at least by age 12, it is recommended that this brochure be annually distributed to youth receiving psychotropic medications as long as they are under the court's jurisdiction.

   With ongoing efforts to achieve permanency, it is hoped that the number of these youth will be small. Annual distribution of this informative document is recommended because young people often lose things.

   Currently, along with an approved Psychotropic Medication Application (PMA), the DCFS PMA unit mails various informational documents to caregivers to be provided to youth. DCFS has now agreed that the PMA unit will begin including the Children's Bureau brochure in the informational packets that accompany approved PMAs mailed to caregivers and youth.

5. The fifth potential mechanism flows from a suggestion made by the California Youth Connection (CYC), a regular and important member of our Psychotropic Medication Workgroup.

   It is recommended that CYC work with the Department of Children and Family Services, the Probation Department, the Department of Mental Health, and others to develop trainings for youth designed to provide information on psychotropic medication, their own involvement in the process, decision-making, self-advocacy, and more.

6. The sixth mechanism stems from a Transition-Age Youth Transition Worksheet created by Court-Appointed Special Advocates (CASA). A draft Psychotropic Medication Youth Engagement Worksheet appears as Attachment 6.

Beginning at age 14 and as long as a youth is under court jurisdiction (until the age of 18), it is recommended that this worksheet be completed by the social worker and attached to the report for every status-review hearing. At those hearings, the court should inquire of youth who are present whether or not they have seen the form and have any comments. In addition, attorneys for the youth and/or caregiver and CASAs who are present should be asked whether they have reviewed the forms and believe the information contained therein is accurate, and be further asked for any other comment.[2]

DCFS and DPH have developed a plan whereby social workers preparing to submit a JV-224 form will prompt PHNs co-located in DCFS offices to complete the work-sheet for timely return to the CSW to attach to the JV-224 prior to court submission.

7. The last mechanism involves public health nurses (PHNs).

It is recommend that the Department of Public Health designate PHNs who are available for the purposes of advice and consultation for all youth, especially those who have reached the age of majority and beyond, and are still under court jurisdiction.

Youth in the Juvenile Justice System

1. First, the utilization of the Judicial Council forms is the same as in child welfare.

2. Second, ***it is recommended that the Making Healthy Choices brochure (Attachment 5) be annually distributed to all youth receiving psychotropic medications while they are under court jurisdiction.***

3. Third, ***it is recommended that the Probation Department work with CYC and other stakeholders to develop trainings that could be delivered to youth in camps, juvenile halls, and other placement locations.***

4. Fourth, ***it is recommended that the Psychotropic Medication Youth Engagement Worksheet (Attachment 6) be completed by Probation and attached to the final camp progress report and to reports for all status-review hearings.***

   Probation is in discussions with DPH to develop a plan to implement this recommendation.

If you have any questions, please contact me at (213) 893-1152 or by email at mnash@ocp.lacounty.gov, or your staff may contact Carrie Miller at (213) 893-0862 or by email at cmiller@ocp.lacounty.gov.

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[2] DCFS, Probation, and the Court have agreed to work with the OCP to develop an implementation plan for the worksheet over the next few months.

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Executive Office, Board of Supervisors
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Chapin Hall Issue Brief

Policy research that benefits children, families, and their communities

November 2017

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The Use of Psychotropic Medications over Time among Foster Youth Transitioning to Adulthood

By Keunhye Park, Nathanael J. Okpych, Mark E. Courtney

Introduction

High rates of psychotropic medication use among children and adolescents in foster care have concerned researchers (Breland-Noble et al., 2004; Brenner, Southerland, Burns, Wagner, & Farmer, 2014; Leslie et al., 2010; Raghavan et al., 2005) and led the federal government to respond (Sheldon, Berwick, & Hyde, 2011; U.S. Government Accountability Office, 2017). Through the Child and Family Services Improvement Act of 2006, the US Congress mandated state child welfare agencies to develop plans to monitor the use of psychotropic medications administered to children in state care (Congressional Research Service, 2017).

In California, the state with the largest foster youth population in the US, three senate bills (SB 238, SB 484, and SB 1174) were enacted in 2015 and 2016 to improve oversight of psychotropic medication use among children in foster care. SB 238 mandates that the state develop curriculum to train professionals involved with the oversight of children in foster care (e.g., foster parents, relative caregivers, group home staff, social workers, juvenile court judges, attorneys, and foster care public health nurses) on the authorization, uses, risks, benefits, oversight, and monitoring of psychotropic medications and mental health treatments. This bill also changed the authorization process for providing psychotropic medications to foster youth to ensure that caregivers and youth had an opportunity to provide input on the use of the medications being prescribed. SB 484 pertains to children in group home facilities; it requires psychotropic medications to be recommended by a physician and ordered by a juvenile court judicial officer and increases the monitoring, reporting, and oversight of psychotropic medication use in these facilities. Finally, SB 1174 orders prescribing physicians to share data with the Medical Board of California about physicians' prescription patterns when treating foster care children covered by Medi-Cal, California's Medicaid program. These data are intended to ensure appropriate uses of psychoactive medications and to create treatment guidelines that will be disseminated each year to physicians who provide

services reimbursed by Medi-Cal.[1] The passage of these bills followed a state audit reporting that child welfare jurisdictions failed to perform appropriate oversight of medication prescriptions to children in foster care (California State Auditor, 2016).

Most research to date on psychotropic drug use in foster care has focused on school-age children (e.g., Zima, Bussing, Crecelius, Kaufman, & Belin, 1999a) and reports that children in foster care are more likely than their peers not in care to be prescribed psychoactive medication and to be treated with more types of medications (dosReis et al., 2011). Previous research has shown that while between 4 and 10 percent of Medicaid-enrolled children used psychotropic medications, 30 to 43 percent of children in foster care used such medications (dosReis, Zito, Safer, & Soeken, 2001; Ferguson, Glesener, & Raschick, 2006; Zito, Safer, Zuckerman, Gardner, & Soeken, 2005; Zito et al., 2008). Less is known about psychotropic medication use among older adolescents in foster care and changes over time in their medication use. Some studies suggest that adolescents in care have higher rates of psychotropic drug use than younger children in care (Brenner et al., 2014; Raghavan & McMillen, 2008; Zima et al., 1999a). One large study of over 700 transition-age foster youths in three Midwestern states reported that the prevalence rates of both behavioral health problems and medication use declined from ages 17 to 19 (Courtney, Terao, & Bost, 2004; Courtney et al., 2005). Furthermore, another analysis of the same study found that, among youths who had a behavioral health problem, the proportion of youths who received behavioral health services (psychotropic medication, psychological counseling, or alcohol/drug treatment) decreased from age 17 to age 19 (Brown, Courtney, & McMillen, 2015). For instance, 61 percent of 17-year-olds with depressive symptoms received behavioral health services, which dropped to 45 percent for 19-year-olds with depressive symptoms.

While these studies provide a sense of trends in psychotropic medication use over time, we know even less about foster youths' perceptions of their psychotropic medications. Stigma around psychotropic drug use (e.g., secrecy, shame, limiting social interaction) is a commonly reported experience among adolescents who take these medications (Kranke, Floersch, Townsend, & Munson, 2010). From a developmental perspective, older adolescents have increased autonomy and agency about their medication decisions, such as weighing the costs and benefits of taking medication. Thus, youths' experiences with and perceptions of their medication use can potentially influence whether they continue treatment and adhere to prescribers' treatment recommendations.

In this memo, we explore the use of and experiences with psychotropic medications over time for California foster youth transitioning to adulthood. We also examine how psychotropic drug use differs for youth who have different types of behavioral health problems. Throughout this memo, "behavioral health problems" will be used to denote both mental health problems and alcohol/drug use problems.

Study Methods

This memo draws on information collected from two interview waves of the California Youth Transitions to Adulthood Study (CalYOUTH). CalYOUTH is a longitudinal study following over 700 transition-age adolescents who had been in foster care in California for at least six months (Courtney, Charles, Okpych, Napolitano, & Halsted, 2014; Courtney et al., 2016). Most respondents were 17 years old during the baseline interview conducted in 2013 and 19 years old during the follow-up interview conducted in 2015. This memo includes information from the 611 youths who completed both interview waves. The baseline interview used a stratified random sampling method to select

[1] In addition to these three laws, a fourth bill (SB 1291), enacted in 2016, focused on Specialty Mental Health Services, with some attention paid to psychotropic medication. SB 1291 requires that an external organization conduct annual mental health plan reviews of the number and types of mental health services provided to children in foster care. It also mandates that quality assessments be reported to the State Department of Health Care Services and then to county boards to assist with the creation of mental health service plans and performance outcomes metrics.

participants for the study. Sample weights are used in the current analysis to account for the sampling design and response rates. The findings reported in this memo represent estimates of the statewide population of foster youth who met CalYOUTH criteria (see Courtney et al., 2014 and Courtney et al., 2016 for more information about survey weights). In the tables and figures throughout this memo, we report findings from both age 17 and age 19, using unweighted frequencies and survey weighted percentages.

At each interview wave, a brief structured diagnostic tool was used to identify the presence of several current mental health disorders and substance use disorders (see Courtney et al., 2014 and Courtney et al., 2016 for more information). In this memo, we consider seven behavioral health problems that were assessed during both interview waves: major depressive episode, manic or hypomanic episode, social phobia, posttraumatic stress disorder, psychotic thinking,[2] alcohol use problems (abuse or dependence), and substance use problems (abuse or dependence).

In terms of psychotropic medication use, respondents were asked if they had received medications for their emotions in the past year. Furthermore, to gauge youths' experiences with their medication, we asked youth to respond to the following four statements: "medicine improves my mood or helps me concentrate or behave better," "I get along better with people when on medication," "my medicine gives me bad side effects," and "good things about medication outweigh the bad." For each statement, respondents could select from one of five responses, ranging from "strongly disagree" to "strongly agree." In this memo, we collapsed the five options into three categories that represent disagreement with the statement, a neutral stance, and agreement with the statement.[3] None of the items in this memo had more than 10 percent missing data.

The findings presented in this memo are organized in three sections. In the first section, we look at overall rates of behavioral health problems, medication use, and receipt of counseling. Differences in rates by gender, race/ethnicity, and sexual minority status[4] are also explored. In the second section, we examine rates of specific behavioral health problems, as well as the rates of medication use among youths who had those specific behavioral health problems. Finally, the third section considers youths' experiences with and perceptions of the effects of their medication.

Findings

A snapshot of behavioral health problems, medication use, and receipt of counseling over time

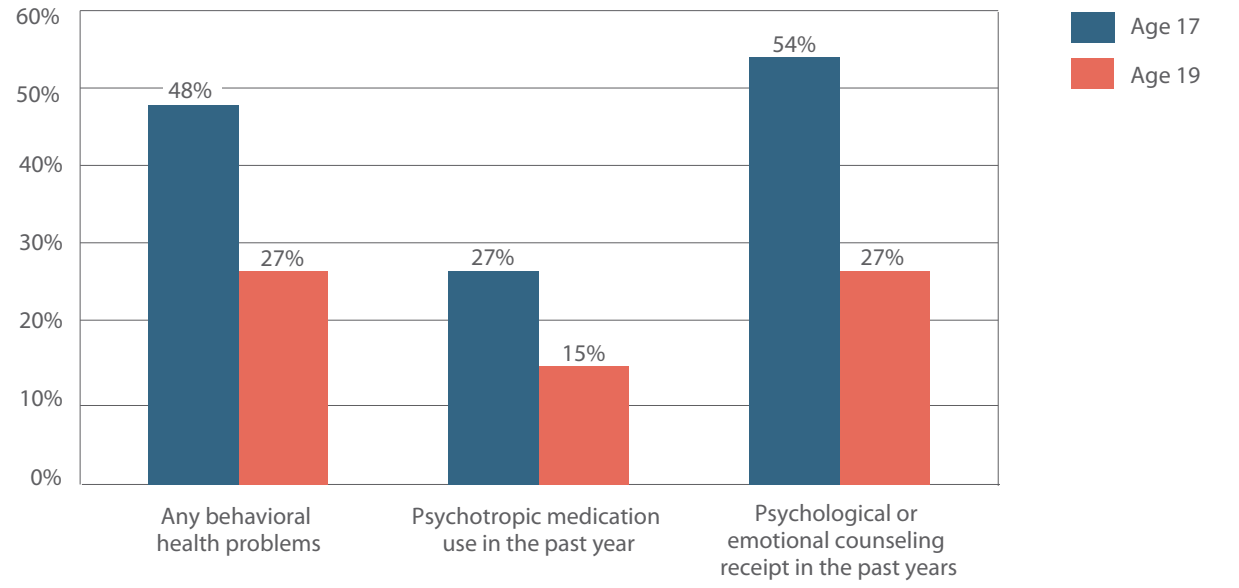
The three sets of bars in Figure 1 display (1) the proportion of respondents with at least one of the seven current behavioral health problems that were screened at each interview wave, (2) the proportion of respondents who reported taking psychotropic medications at each interview wave, and (3) the proportion of respondents who reported receiving psychological or emotional counseling at each interview wave. All three prevalence rates declined from age 17 to age 19. The proportion of youth with a behavioral health problem dropped by more than two-fifths ($p < .001$), as did the proportion of youth taking psychotropic medication ($p < .001$). The proportion of youth receiving counseling dropped by half from age 17 to age 19 ($p < .001$).

[2] Symptoms of psychotic thinking were assessed using different instrument tools at each interview wave. The MINI-KID was used at age 17 (Sheehan et al., 1998, 2010), and the Psychoticism Dimension of the Symptoms Checklist-90-Revised (SCL-90-R) was used at age 19 (Derogatis, 1996; Derogatis & Unger, 2010).

[3] The original response options for these questions ranged from 1 through 5 (1 = strongly agree; 2 = agree; 3 = neither agree nor disagree; 4 = disagree; 5 = strongly disagree). The three-category measure used in this analysis included an affirmative response ("agreed" or "strongly agreed"), a neutral response ("neither agree nor disagree"), and a disagreeing response ("disagreed" or "strongly disagreed").

[4] Sexual minority status was assessed by one item asking about youths' sexual orientation. The response options included: 100% heterosexual, mostly heterosexual, bisexual, mostly homosexual, 100% homosexual, and not sexually attracted to either males or females. A binary variable with two categories was created based on whether youth reported being 100% heterosexual or not.

Figure 1.
Proportion of Youths with Behavioral Health Problems, Proportion of Youths Using Medication for Emotions, and Proportion of Youths Receiving Counseling Services (n = 611)



We found statistically significant differences in rates of behavioral health problems by gender and sexual orientation. Females were more likely than males to screen positive for a behavioral health problem at age 17 (53% vs. 41%, $p < .05$). Additionally, a greater proportion of sexual minority youths than youths who identified as 100 percent heterosexual screened positive for at least one behavioral health disorder at both age 17 (66% vs. 44%, $p < .001$) and at age 19 (40% vs. 23%, $p < .01$). There were no statistically significant differences by race and ethnicity in the prevalence rates of behavioral health problems.

Regarding psychotropic medication use, there were no significant racial/ethnic differences or gender differences at age 17 or at age 19. However, differences were found by sexual orientation. Sexual minority youths were more likely than youths who identified as 100 percent heterosexual to receive psychotropic medications at age 17 (37% vs. 23%, $p < .01$) and at age 19 (22% vs. 13%, $p < .05$).

Lastly, the proportion of youths receiving psychological or emotional counseling significantly differed by gender and sexual orientation, but did not differ by race and ethnicity. Females were more likely than males to receive mental health counseling at age 17 (59% vs. 45%, $p < .01$). Moreover, a greater proportion of sexual minority youths than youths who identified as 100 percent heterosexual reported receiving counseling services at age 17 (67% vs. 48%, $p < .001$) and at age 19 (35% vs. 24%, $p < .05$). We also examined the proportions of youths receiving counseling services among those who used psychotropic medications. The results showed that the vast majority of youths using psychotropic medications also received counseling services at both ages (84% at age 17, 80% at age 19).

A closer look at prevalence rates of specific behavioral health problems and prevalence rates of psychotropic medication use among those with behavioral health problems

In the previous section, we looked at overall prevalence rates of behavioral health problems and the use of psychotropic medications at age 17 and age 19. In this section, we take a closer look at specific mental health and substance use problems and how the prevalence rates changed from age 17 to age 19. We also examine the proportions of youths who used psychotropic

medications among those with a specific behavioral health problem and how these prevalence rates differed between age 17 and age 19.

The left columns of Table 1 ("% screened positive for disorder") present the prevalence rates of specific behavioral health problems at age 17 and age 19 among all participants in each interview wave. The middle columns of Table 1 ("% receiving psychotropic medications, among those who screened positive for disorder") present the proportion of respondents who used psychotropic medications, among the youths who had screened positive for the corresponding behavioral health problem. For example, at age 17, 48 percent of respondents screened positive for one or more behavioral health problems. Among youths with at least one behavioral health problem at age 17, almost 38 percent had used psychotropic medications in the past year.

At age 17, 48 percent of youths screened positive for either a mental health or substance use disorder and 12 percent had a co-occurring mental health problem and a substance use problem. The most prevalent behavioral health disorders were a drug use disorder (nonalcohol) and depression. At age 19, 27 percent of youths screened positive for either a mental health or substance use disorder, and 6 percent had both mental health and substance use problems. The most prevalent behavioral health disorders were also depression and nonalcohol drug use problems, as well as symptoms of psychotic thinking. Prevalence rates of behavioral health problems were generally lower at age 19 than at age 17, with significant declines found for most disorders except for psychoticism and social phobia.

As shown in the middle columns of Table 1, rates of psychotropic medication use among youths with behavioral health problems were generally lower at age 19 than at age 17. The prevalence rate of medication use declined by 12 percentage points for youths with any behavioral health problems ($p < .05$). The prevalence rate of psychotropic medication use dropped by 26 percentage points for youths with co-occurring mental health and substance use disorders ($p < .01$). Looking at specific behavioral health problems, significant decreases were found in medication use from age 17 to age 19 in youths with the following disorders: a manic episode (a decrease of 26 percentage points; $p < .05$), an alcohol use disorder (a decrease of 25 percentage points; $p < .01$), and a nonalcohol drug use disorder (a decrease of 18 percentage points; $p < .05$). However, additional analyses found that the drop in psychotropic medication use among youths with an alcohol/drug use problem was explained, in part, by the accompanying drop in the prevalence of co-occurring mental health problems from age 17 to age 19.[5]

Lastly, although not the focus of this memo, we also examined the proportion of youth with behavioral health problems that had received counseling.[6] The right columns of Table 1 ("% receiving counseling, among those who screened positive for disorder") present the proportion of respondents who received emotional or psychological counseling, among the youths who had screened positive for the corresponding behavioral health problem. Overall, greater proportions of youth with behavioral health problems received counseling than psychotropic medications. For example, at age 17, about 65 percent of youths with a behavioral health problem received counseling while 38

[5] Note that the proportion of youths with co-occurring disorders dropped from 11.5% to 5.9% from age 17 to age 19. That is, among youths with a substance use problem at each interview wave, a smaller percentage at age 19 than at age 17 also had a mental health problem. We suspected that this drop in co-occurring mental health problems may have accounted for some of the decline in psychotropic medication use observed among youths with substance use disorders. To investigate this, we compared the rates of psychotropic medication use across ages among youths who only had a substance use problem (i.e., no co-occurring mental health problem). In this analysis, the difference in rates of psychotropic medication use between ages was just 10 percentage points for an alcohol use disorder (30% vs. 20%), 13 percentage points for a drug use disorder (35% vs. 22%), and 14 percentage points for any alcohol/drug disorders (33% vs. 19%). None of these three differences were statistically significant ($p > .10$). This suggests that the decline in the psychotropic medication use among youths with substance use disorders is explained, at least in part, by the drop in the prevalence of co-occurring mental health problems

[6] At each interview wave, the study participants were asked the following question about their receipt of outpatient mental health services: "In the past year, have you received psychological or emotional counseling?"

Table 1.
Prevalence of Specific Behavioral Health Problems (n = 611) and Psychotropic Medication Use among Youths with Behavioral Health Problems (n = 177 at age 17, n = 106 at age 19)

	% screened positive for disorder		Between ages	% receiving psychotropic medications, among those who screened positive for disorder		Between ages	% receiving counseling, among those who screened positive for disorder		Between ages
	Age 17	Age 19	*p*	Age 17	Age 19	*p*	Age 17	Age 19	*p*
Mental health and/or substance use disorders									
Either mental health disorder or substance use disorder	48.0	27.3	***	37.8	25.7	*	64.8	41.5	***
Both mental health disorder and substance use disorder	11.5	5.9	**	54.2	28.1	**	72.6	51.1	*
Mental health disorders									
Major depression episode	21.5	9.6	***	45.7	40.1		74.9	60.6	
Mania (manic episode or hypomanic episode)	13.5	2.3	***	45.5	19.5	*	70.5	39.5	*
Psychotic thinking	7.9	9.0		38.9	35.1		58.9	51.9	
PTSD	7.2	3.0	**	62.6	39.3		73.6	46.6	
Social phobia	5.0	4.8		46.3	38.9		63.8	67.2	
Any mental health disorder	33.1	18.7	***	40.1	28.6	*	69.5	50.0	**
Substance use disorders									
Alcohol abuse or dependence	12.7	8.5	*	44.4	19.8	**	58.9	32.3	**
Drug abuse or dependence	22.7	9.4	***	44.8	26.5	*	65.6	38.7	***
Any substance use disorder	26.5	14.1	***	42.2	23.0	**	62.3	35.0	***

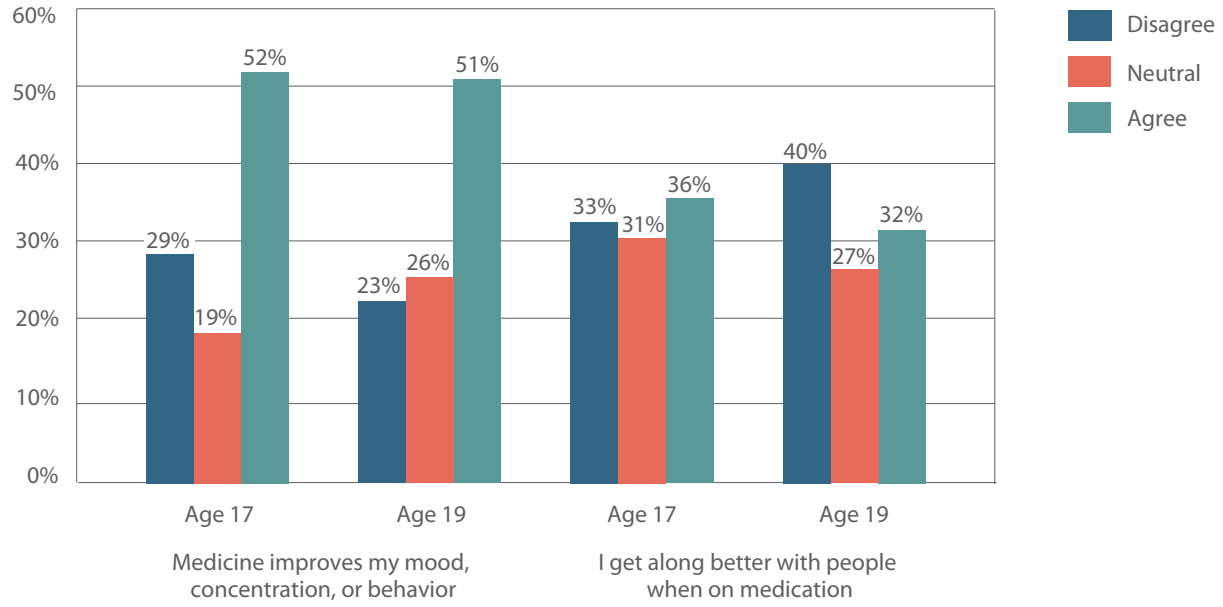
*p < .05; **p < .01; ***p < .001

percent of youths received psychotropic medications. As shown in the table, youth with behavioral health problems experienced a drop in counseling use from age 17 to age 19. The proportion of youths who had received counseling declined by 23 percentage points for youths with any behavioral health problem (p < .001) and by 22 percentage points for youths with co-occurring mental health and substance use disorders (p < .05). Looking at specific behavioral health problems, significant decreases were found in counseling use from age 17 to age 19 for the following disorders: a manic episode (a decrease of 31 percentage points; p < .05), an alcohol use disorder (a decrease of 27 percentage points; p < .01), and a nonalcohol drug use disorder (a decrease of 27 percentage points; p < .001).

Youths' experiences with and perceptions of psychotropic medication use

This section provides information about youths' perceptions of the effects, benefits, and downsides of their psychotropic medication, at both age 17 and age 19. Importantly, for all comparisons between ages 17 and 19 described below, no statistically significant differences were found. However, this analysis in particular includes relatively small numbers of youths at each interview wave who reported using psychotropic medication. Thus, there may have been inadequate statistical power to detect differences in medication experiences.

Figure 2.
Youths' Perceptions of the Effect of Psychotropic Medication on Their Mood and Interaction with Others (*n* = 177 at age 17, *n* = 106 at age 19)



As seen in the left half of Figure 2, respondents using psychotropic medication were asked whether their medication improved their mood, concentration, or behavior. At both ages 17 and 19, about one-half of youths agreed that their medication had those positive benefits, while the rest had a neutral or negative view about the benefits.

The right half of Figure 2 shows that at age 17, roughly equivalent proportions (about one-third) of youths disagreed, had a neutral view, or agreed that medications helped them get along better with others. At age 19, somewhat similar proportions of youth had positive, negative, and neutral perceptions of the effects of psychotropic medications, with no statistically significant difference between responses at 19 and those two years earlier.

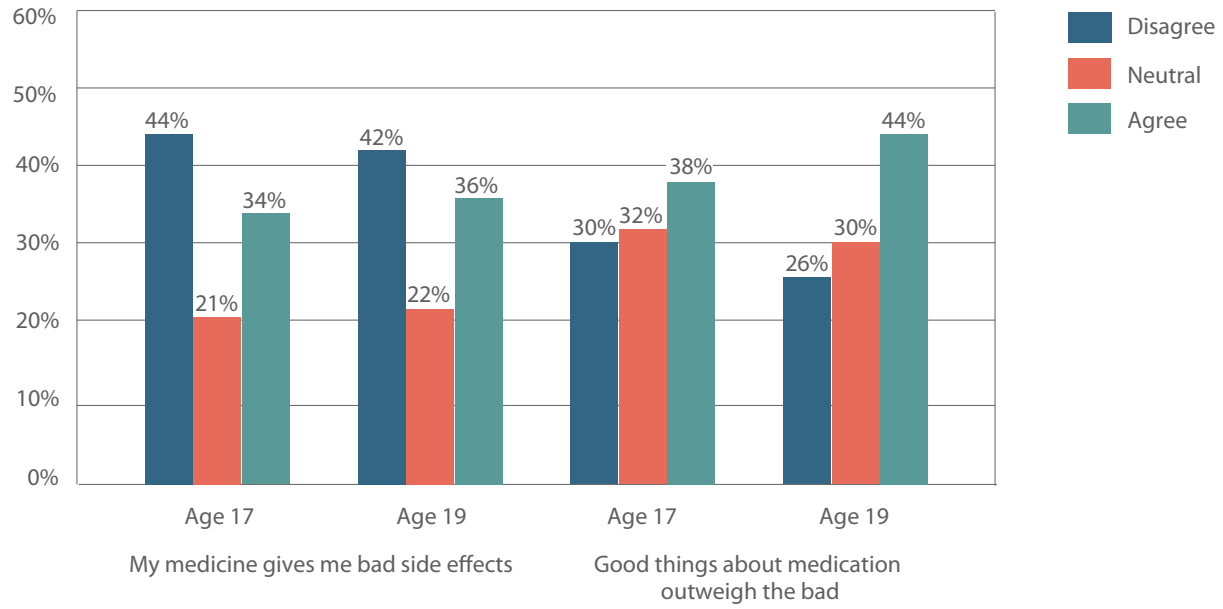
Respondents were also asked about the negative side effects of their psychotropic medications, and their responses appear in the left half of Figure 3. Responses about negative side effects were very similar between ages 17 and 19. At both ages, over four in ten youths disagreed that their medication gave them bad side effects, over two in ten were neutral about the negative side effects, and less than four in ten reported that there were negative side effects from their medication.

A final question pertained to the net benefits of psychotropic medications, asking respondents whether the good things about their medication outweighed the bad things. The right half of Figure 3 shows that the majority of youths who had used medication reported a positive or neutral view with respect to whether the advantages of using medications outweighed the disadvantages (70% at age 17, 74% at age 19).

Study Limitations

It is important to note several limitations of the study. First, the measures of behavioral health disorders collected in this study were self-reported by respondents using a brief screening tool rather than a formal diagnostic assessment. Second, time constraints of conducting the survey prevented us from gathering more specific information on youths'

Figure 3.
Youths' Perceptions of the Side Effects and Net Benefits of Their Psychotropic Medication (*n* = 177 at age 17, *n* = 106 at age 19)



psychotropic medication. For example, we did not have data on the specific types of medication youths were taking, how many medications youths were prescribed, and which mental health problem(s) the medication was intended to treat. Moreover, the question about psychotropic medications asked about "medications for emotions," which may not have captured the total array of psychoactive drugs used to treat behavioral health problems. Information was also not collected on the types of side effects youths experienced or on the effects that they felt were most problematic or concerning. This information would be especially relevant when examining benefits and side effects of specific types of psychotropic medications, which may have different sets of side effects. Small sample sizes, particularly in the analyses involving subgroups of the study sample (i.e., youths with a specific behavioral health problem, youths who used psychotropic medications), may have limited the statistical power to detect significant differences. Finally, the study findings may not represent the experiences of youth in other states, due to differences in youth characteristics as well as differences in policies and practices in the child welfare systems and behavioral health care systems.

Summary and Implications

Overall rates of psychotropic medication use at age 17

Among CalYOUTH participants, 27 percent of 17-year-olds indicated that they had used medication for their emotions in the past year. These estimates are consistent with recent estimates based on administrative records of the statewide prevalence of psychotropic medication use, which reported that 26 percent of children ages 16 and 17 in California foster care were prescribed psychotropic medication during a 12-month period (April 2016 through May 2017; California Child Welfare Indicators Project [CCWIP], 2017). There were differences between the CalYOUTH Study and state administrative records in the source of data, the ages of the samples, and the measurement of psychotropic

medication use.[7] Despite these differences, the psychoactive drug use estimates were similar between studies.

Consistent with prior studies, the high rates of psychotropic medication use among older adolescents in foster care call for attention from child welfare professionals, social workers, clinicians, and caregivers. One promising finding is that counseling services for emotional and psychological problems were used by more youth than were psychotropic medications. This suggests that psychotropic medications are not being used as the predominant treatment of behavioral health problems. Moreover, the fact that the vast majority of youth using psychotropic medications were also seeing a counselor at the time suggests that their use of these drugs is likely done with the oversight of a mental health professional.

Differences in psychotropic medication use by subgroups

When looking at prevalence rates by subgroups (gender, race/ethnicity, and sexual orientation), sexual minority youths were more likely than their sexual majority counterparts to have behavioral health problems, to use psychotropic medications, and to receive psychological or emotional counseling. Additional analyses (not shown) indicate that, among youths with a behavioral health problem, sexual minority youths were more likely than sexual majority youths to have received psychotropic medications (47% vs. 33% at age 17, $p < .05$; 38% vs. 19% at 19, $p < .05$). As sexual minority youth are often likely to experience marginalization and exclusion in their families, communities, and schools (Hammack & Cohler, 2011), it is essential to ensure that their psychotropic medication yields clinical benefits to them and is accompanied by treatment that addresses social stigma, isolation, and discrimination. In this study, nearly one-fourth of respondents at age 17 reported their sexual orientation as being something other than 100 percent heterosexual. Future work should further explore differences in the use of psychotropic medications by sexual orientation, including differences in behavioral health problems that prompt the use of psychotropic medication.

Changes in psychotropic medication use from age 17 to age 19

Our findings show notable changes in overall rates of behavioral health problems and medication use from age 17 to age 19. Among all respondents, both prevalence rates of behavioral health problems and psychotropic medication use dropped from age 17 to age 19. Among youths with a behavioral health problem, the rate of medication use also declined significantly from age 17 to age 19. The findings are consistent with existing studies that have examined trends in service usage, showing that foster youth with behavioral health issues transitioning to adulthood are less likely to receive ongoing treatment as they reach adulthood (Brown et al., 2015; Courtney, Piliavin, Grogan-Kaylor, & Nesmith, 2001). The significant decline in medication use was observed among youths who screened positive for any mental health problem at ages 17 and 19. While the significant drops in medication use were also found in youths with any alcohol/drug use problems at ages 17 and 19, this was explained, at least in part, by the accompanying decrease in youths with co-occurring mental health problems.

Why might we see declines over time in psychotropic medication use?

Decreases in medication use between ages 17 and 19 among youths with behavioral health problems could be explained by a confluence of structural barriers, changes in living context, and changes in personal preferences. Structural barriers may include discontinuity in

[7] There are some differences between the CalYOUTH Study and the California Department of Social Services (CDSS) in how psychotropic medication use was measured. First, the CalYOUTH Study analyzed self-reports of medication use , while the CDSS measure came from administrative data on paid claims from Medi-Cal pharmacy providers. Second, the CalYOUTH Study sample (mostly 17-year-olds) was older than the adolescents in the CDSS data (16- and 17-year-olds). Third, the CalYOUTH Study asked youth a general question about "medications [they] received for [their] emotions," whereas the CDSS measure captured classes of medications designed to treat specific psychological disorders (i.e., anxiolytic agents, antidepressants, mood stabilizers, antipsychotic medications, anti-Parkinson agents, hypnotics, medications for dementia, and psychostimulants; CCWIP, 2017).

systemic supports upon exit from care, challenges in accessing services or navigating services, or difficulties with transportation and appointment availability (Brown et al., 2015; Dworsky, Ahrens, & Courtney, 2013; Reilly, 2003; Sakai et al., 2014).

Changes in living context might also explain the drop in medication use as youth transition to adulthood. At age 17, more than half of the participants lived in a placement with a therapeutic component (31% were placed in therapeutic foster care homes and 23% resided in a group home or residential treatment center). At age 19, fewer youths resided in placements with more restrictions or a therapeutic component (e.g., 7% lived in therapeutic foster homes and 15% lived in transitional housing placements). The majority of youths at age 19 lived in relative or nonrelative foster homes (27%), in supervised independent living placements (24%), were out-of-care and lived with friends or relatives or in their own place (18%), or lived in some other setting (9%). Compared to the living arrangements at age 17, on average, the places youths lived at age 19 had less supervision and support by professionals or adults who are in a position to encourage youths to take advantage of needed behavioral health services and help them navigate the steps needed to receive medication (e.g., completing paperwork, scheduling an appointment, finding transportation, refilling prescriptions).

Furthermore, changes in personal preferences about medication use might also factor in to these trends. As youth become more independent in making choices during the transition to adulthood, their perceptions about side effects of medication, their desire to deal with behavioral health problems on their own, and their willingness to seek nondrug treatments may influence their decision to use psychotropic medications. More research is needed to explain the downward trend in medication use as foster youth transition to adulthood.

Youths' experiences with psychotropic medications

In terms of medication experiences, overall our findings suggest that most youths had favorable or neutral views about the effects of their psychotropic medications. Those views did not change significantly over time. However, a nontrivial minority of participants at each interview wave expressed negative views or experiences—they felt that their medication did not improve their mood or their interactions with others, they experienced negative side effects, or they did not perceive that the positive aspects of their medication outweighed the negative aspects. From a quality assurance perspective, it is important to consider youths' negative reports about their medication experiences because this could signal an issue with their current prescriptions (e.g., dosage or type(s) of medication) or a need for a different or an additional treatment approach. Further, included in this population are youths approaching adulthood or who have reached the age of majority. From a consumer's perspective, since these young people exercise a greater degree of autonomy and discretion in their use of psychotropic medications than younger children do, information collected about their experiences accessing and navigating services, their interactions with prescribers, and their views about medication benefits are important indicators of treatment satisfaction and service performance. These data may be particularly important for young people living in placements where there is less oversight and support and where the responsibility falls on them for obtaining and using psychotropic medications.

These findings also have implications for professionals working with transition-age foster youth who take psychotropic medications. The ways in which youths come to see and understand their need for medication, the benefits of medication, and interpretation of the side effects are co-constructed through dialogues youths have with providers, professionals, and other significant individuals in their lives (Longhofer, Floersch, & Okpych, 2011; Townsend, Floersch, & Findling, 2009). Thus, these people play an important role in shaping how youth view themselves in relation to their behavioral health issues, how youth make sense of ambivalence and other feelings around taking medication, and whether youth stick to the treatment regimens to increase the chances that the medication will have its intended benefits. Professionals in the child

welfare and mental health fields need to be prepared to engage foster youth in conversations that will increase youths' competency and comfort with making decisions about addressing their behavioral health issues.

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Related Publications

Okpych, N. J., Courtney, M., & Dennis, K. (2017). *Memo from CalYOUTH: Predictors of high school completion and college entry at ages 19/20.* Chicago, IL: Chapin Hall at the University of Chicago.

Courtney, M. E., Park, E., & Okpych, N. J. (2017). *Memo from CalYOUTH: Factors associated with remaining in foster care as young adults.* Chicago, IL: Chapin Hall at the University of Chicago.

Courtney, M. E., & Okpych, N. J. (2017). *Memo from CalYOUTH: Early findings on the relationship between extended foster care and youths' outcomes at age 19.* Chicago, IL: Chapin Hall at the University of Chicago.

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RESOLUTION REGARDING JUDICIAL OVERSIGHT OF PSYCHOTROPIC MEDICATIONS FOR CHILDREN UNDER COURT JURISDICTION

WHEREAS, Judges recognize that each child under court jurisdiction is unique, valued and entitled to individualized attention;

WHEREAS, Medicaid data indicate children in foster care are prescribed psychotropic medications far more often than children in the general population;

WHEREAS, Judges in child welfare and juvenile justice cases are responsible for overseeing the safety and well-being of children under court jurisdiction;

WHEREAS, the NCJFCJ believes that this oversight responsibility extends to children prescribed psychotropic medications, including ensuring that medications are safe and appropriate; and

WHEREAS, the NCJFCJ believes that judicial oversight means, at a minimum, that each court:

- Is aware of every child who is being prescribed psychotropic medications, and has the following information:
  - the names and dosages of all psychotropic medications being prescribed as well as all other medications being prescribed and taken,
  - the reason for the prescription(s),
  - the alternatives to medications that have been considered,
  - the other interventions that should accompany or are accompanying the use of the medications,
  - the actual effects of the medications, both beneficial and adverse,
  - the name of the medical professionals prescribing the medications and their qualifications, and
  - the individual responsible for administering the medication to the child.
- Ensures a qualified medical professional is timely and thoroughly monitoring the medications.
- Ensures there are protocols in place to maintain the medication regimen without interruption when any placement changes occur.
- Ensures parents are fully involved and informed about the use of the medications and the reason for their use, and have the ability to maintain the regimen or meaningfully decide, in consultation with medical professionals, whether and how to discontinue medications during reunification or upon return to their custody.

- Ensures all other caregivers are fully informed of the use of the medications and the reasons for them and have the ability to maintain the medication regimen in consultation with medical professionals.
- Ensures children have been engaged at the earliest possible time in the medication process, allowing the court to have an understanding of their attitude toward medications and whether additional services or resources will be necessary to assure medication compliance.
- Ensures all children transitioning from child welfare or juvenile justice who are being administered psychotropic medications have been educated sufficiently to maintain their medication regimen and make decisions about their care, including possible adverse effects of sudden discontinuation of psychotropic medications.

BE IT THEREFORE RESOLVED AS FOLLOWS:

NCJFCJ shall promote the exercise of judicial leadership to convene and engage States and other jurisdictions, communities, and stakeholders in the child welfare and juvenile justice systems in meaningful partnerships to encourage and to ensure, when necessary, the appropriate use of psychotropic medications for children and youth under court jurisdiction.

NCJFCJ is committed to development of technical assistance resources to assist judges in fulfilling the oversight role described in this resolution.

NCJFCJ is committed to educating judges on issues related to psychotropic medications, including but not limited to, the safe and appropriate use of psychotropic medications and recommended practices for judicial oversight.

NCJFCJ remains committed to educating judges on the substantial impact trauma can have on children and families and how psychotropic medications are most appropriately used when trauma is present.

NCJFCJ encourages engaging parents, caregivers, and others involved in the care, supervision and treatment of the child to be educated regarding the appropriate use of psychotropic medication for children.

NCJFCJ shall advocate for information sharing among those involved in the care and treatment of children under court jurisdiction and for the development and use of technology to enhance information sharing among all entities responsible for the care of children under court jurisdiction.

NCJFCJ supports the development of consultation resources for those courts that are charged with making decisions regarding the use of psychotropic medications for children under court jurisdiction.

NCJFCJ encourages the further study of, and the continued analysis of available data on, effective interventions and outcomes for children prescribed psychotropic medications with particular emphasis on disproportionately impacted populations.

Adopted by the NCJFCJ Board of Trustees during their Annual Meeting, July 13, 2013, Seattle, Washington.

DCFS HEALTH & MEDICATION GUIDE

Children and youth in foster care must receive education and training enabling them to make informed decisions about their health and mental health. For example, some children/youth have severe diabetes and cannot survive without insulin; and others take psychotropic medication for mood stabilization. It is critical that children and youth in foster care develop an understanding of their medical and/or psychiatric conditions, and know how to continue treatment, and access their medication in preparation for the day when jurisdiction is terminated over their case. Following are guidelines designed to prepare children and youth in foster care to make their own health and mental health decisions.

NOTE: Administration of medication by caregivers or self-administration by children/youth, must be in compliance with State of California Title 22 Community Care Licensing Regulations.

DCFS Goals & Milestones Guidelines		
Age		**Children and youth in foster care should have practical experience that allows them to reach the following goals/milestones regarding medication:**
0-3		Medications should be dispensed by the caregiver according to instructions on prescription label or as directed by the appropriate medical professional in accordance with Title 22 89475(c). Caregiver should familiarize themselves, via consultation with doctor and pharmacist, with the effects and side effects of medications and what to do in an emergency.
4-7		In addition to the above, using age appropriate language the caregiver should begin to teach the child the name, dose and frequency of the medication, as well as what symptom's it should relieve, so the child can begin to connect the type of medication with the effects (s)he experiences.
8-11		In addition to the above, once the physician of a child/youth has determined that the child/youth has sufficient maturity and gives permission, the child/youth may self-administer medication or injections in accordance with Title 22 89475.1. The caregiver should begin teaching the child/youth to be responsible for taking medications, e.g., use a series of check boxes or calendar or days-of-the week/AM-PM pill dispenser, so

DCFS Goals & Milestones Guidelines		
Age		**Children and youth in foster care should have practical experience that allows them to reach the following goals/milestones regarding medication:**
8-11		the child/youth can check off or track when (s)he took medication. The caregiver must closely monitor to ensure the child/youth takes the appropriate dose. **NOTE:** If a caregiver is uncomfortable with showing a child/youth how to self-administer the medication or injections, the caregiver may seek assistance from the licensed health care professional providing care to the child/youth. The caregiver may also arrange for a licensed health care professional to administer the medication or injections to the child/youth.
12-13		In addition to the above, youth knows which medications (s)he is taking and can articulate why.
14		In addition to the above, with the youth's consent, a trusted adult is identified (family, parent, caregiver, CSW, etc.) who can be made aware of the youth's medical needs.
15-17		In addition to the above, youth should start participating in scheduling their medical and mental health appointments, refilling prescriptions and being responsible for taking medication, with caregiver assistance.
18		In addition to the above, youth should: 1. Understand that even if (s)he remains under DCFS supervision, (s)he will be making her/his own decisions about health and mental health care. 2. Be making his/her own medical and/or mental health appointments and obtaining prescription refills, with caregiver "check-ins." 3. Have copies of health and mental health history, and know how to have it transferred to a new doctor, therapist, etc. This should include: • Contact information for Medical & Dental Health care provider(s) (primary care physician, etc.) • Contact information for Mental Health Care provider(s) (Psychiatrist, Therapist, etc.)

DCFS Goals & Milestones Guidelines	
Age	**Children and youth in foster care should have practical experience that allows them to reach the following goals/milestones regarding medication:**
18	• Medications(s) (List of current and past) • Immunization Record • Hospitalization(s) and why • Diagnosis list • Treatment Plan(s) • Evaluation(s) 4. Know how to access regular care and treatment (make appointments, transportation, Medi-Cal or other payment method, etc.) 5. If check-ups beyond an annual physical are needed, youth should know why, where and with whom (e.g., sickle cell disease check-ups are more frequent than annually). 6. Know about the medications prescribed, including: • List of medication(s) • Why it (each) is prescribed • The correct dosage and frequency • Side effects, "red-flags" and who to call in an emergency • How to refill prescriptions and obtain pharmacist consultation • How to make appointments to change or get new prescriptions • What to do if they wish to stop taking the medication and what the side effects might be

CSW Responsibilities

1. Therapeutic treatment that accompanies medication:
   - Collaborate with the caregiver or parent and health care provider to ensure that counseling, psychotherapy, physical therapy or other therapeutic services that the physician or psychiatrist has prescribed in the treatment plan are accessible.
   - Interview the caregiver and identify any barriers to obtaining medication and compliance with health/mental health treatment plan. Provide assistance in obtaining services to eliminate any identified barriers.

2. Psychotropic Medication Authorization (PMA) process:
   - When contacted by the health or mental health care provider, psychiatrist or physician; Public Health Nurse (PHN); D-Rate Unit staff; or Department of Mental Health Juvenile Court staff (DMHJC), provide information regarding observed behaviors of the child/youth (including reports from or contact with

school, law enforcement or Probation.) Refer to Policy Guide 0600-514.10, Psychotropic Medication: Authorization, Review and Monitoring for DCFS-Supervised Child.

3. Continuity of medication regimens when children/youth change placements:
   - Refer to Policy Guide 0300-503.97, Notice of Replacement Report for specific instructions.

4. Caregivers and parents understand the child/youth's need for medication and/or therapy:
   - Interview the caregiver or parent to confirm (s)he has discussed the child/youths diagnosis and treatment plan (including medication and/or therapy) with the appropriate providers, (e.g., physician, psychiatrist, pharmacist, therapist/counselor.) Refer to Policy Guide 0600-514.10, Psychotropic Medication: Authorization, Review and Monitoring for DCFS-Supervised Child.
   - Work with caregiver, trusted adult(s) and/or other relevant individuals (i.e., Wraparound staff, FFA or Group Home Case Manager, etc.) to ensure each understands the above goals/milestones and what role each will play in assisting the child/youth to reach those goals/milestones.
   - Inform the caregiver of Child Health and Disability Prevention (CHDP) Program and services. Refer to Policy Guide 0600-506.10, Child Health & Disability Prevention (CHDP) Program.

5. Child/youth understands what medications he or she is taking and why:
   - Using age appropriate language, interview the child/youth and confirm (s)he has had a discussion regarding his/her diagnosis and treatment plan (including medication and therapy) with the caregiver/parent and appropriate providers, (e.g., physician, psychiatrist, pharmacist, therapist/counselor.)
   - If children/youth are not meeting the goals/milestones or do not have the information regarding their health/mental health treatment, provide the caregiver or youth (as applicable) linkage to appropriate services. For children 0-17 years of age these may include (but are not limited to): regional center, child/youth mental health services, Wraparound and Full Service Partnership (FSP) Transition Age Youth (TAY). For youth 18 years of age or older linkage to adult services, such as regional center, adult mental health and FSP TAY. Collaborate with DMH, regional center workers or medical professionals to identify potential services, placements, etc.

6. Youth aging out (17 years and 5 months - 18 years old) or transitioning to Extended Foster Care (EFC) (Nonminor Dependents) have the ability to make decisions for themselves regarding health care and medication including psychotropic medication:
   - See goals/milestones section above, as well as the following Policy Guides and Form: 0100-535.60, Youth Development: The 90-Day Transition Plan and Transitioning to Independence; 0100-535.25, Extended Foster Care (EFC)

Program and; the DCFS 6009, Nonminor Dependent (NMD) Informed Consent form.

- Provide the complete Health & Education Passport (HEP) Binder to:
  - ☐ Youth who are aging out of foster care and whose jurisdiction is being terminated or;
  - ☐ Nonminor Dependent (NMD) youth who will no longer be participating in EFC and whose jurisdiction is being terminated or;
  - ☐ Nonminor Dependent (NMD) youth participating in EFC and residing in a Supervised Independent Living Placement (SILP).

  Refer to Policy Guide 0080-505.20, Health & Education Passport (HEP)

7. Documentation:
   - All of the above information gathered is to be documented in the appropriate CWS/CMS Contact Notebook and Health Notebook as appropriate. Additionally, all of the above information is to be documented in the Case Plan, Status Review Hearing Report and the 90-Day Transition Plan (when appropriate).
   - Inform the court and child/youth's attorney of the status of the goals/milestones via the Case Plan, each Case Plan Update and Status Review Hearing report.

DCFS D-Rate Unit Responsibilities:

- Complete the D-Rate Unit duties outlined in Policy Guide 0600-514.10, Psychotropic Medication: Authorization, Review and Monitoring for DCFS-Supervised Child. This includes contact with caregiver or parent regarding the child/youth's psychotropic medication needs and treatment.

Public Health Nurse (PHN) Responsibilities:

- Assist the CSW in obtaining provider cooperation in completing the DCFS 561(a)(b)(c), if needed. This includes discussion with the health/mental health care provider regarding documentation that the condition and treatment were explained to the caregiver and child/youth; whether or not the youth is authorized to self administer his/her own medication, and whether or not the self administration is to be supervised by an adult.
- Provide consultation to the CSW, as needed, for all children/youth with medical or psychiatric issues or concerns. Per existing procedure, the CSW submits the, DCFS 5646-1, Public Health Nursing Consultation Request. NOTE: Copies of the JV-223 are provided to the PHN's. Refer to Policy Guide 0600-530.00, Public Health Nurses (PHNs): Roles and Responsibilities.

Healthcare Provider (Medical/Dental/Psychological) Responsibilities:

- Completes the DCFS 561(a), (b) & (c) documenting whether or not:
  - ☐ Condition and treatment were explained to the caregiver and child/youth (as age appropriate);
  - ☐ Youth may self administer his/her own medication with adult supervision;
  - ☐ Youth is authorized to self administer his/her own medication.

DCFS HEALTH & MEDICATION GUIDE

Policy:

Policy Guides:	
0080-502.10	Case Plans
0080-505.20	Health & Education Passport (HEP)
0100-510.61	Placement Responsibilities
0100-535.25	Extended Foster Care (EFC) Program
0100-535.60	Youth Development: The 90-Day Transition Plan and Transitioning to Independence
0300-503.15	Writing a Status Review Hearing Report for a WIC Section 364, 366.21(e) or (f), 366.22 or 366.25 Hearing
0300-503.97	Notice of Replacement Report
0600-506.10	Child Health & Disability Prevention (CHDP) Program
0600-514.10	Psychotropic Medication: Authorization, Review and Monitoring for DCFS-Supervised Child
0600-530.00	Public Health Nurses (PHNs): Roles and Responsibilities
0700-500.10	Education of DCFS-Supervised Children

Forms:

DCFS 561(a), Medical Examination Form
DCFS 561(b), Dental Examination Form
DCFS 561(c), Psychological/Other Examination Form
DCFS 5646-1, Public Health Nursing Consultation Request
DCFS 6009, Nonminor Dependent Informed Consent

Children's Law Center of California

MEMORANDUM

TO: **Psychotropic Medication Committee**
FROM: **Children's Law Center of California**
DATE: **October 20, 2017**
RE: **Policy Recommendations to Promote Medical Decision-Making Readiness - Revised**

Dependents and wards must have the tools to make informed decisions about their health and mental health by the time they reach adulthood. For example, some child clients have severe diabetes and cannot survive without their insulin; others take psychotropic medication to maintain successful functioning. It is critical that these clients develop an understanding of their medical conditions, and know how to continue treatment and access medication, prior to reaching adulthood. Below are initial policy recommendations that can help to better prepare dependents and wards to make informed medical decisions by the time they reach age 18.

All youth taking medication should be engaged in regular conversation about medication they are taking, why they are taking it and how they feel about taking the medication. Policy and practice should ensure that youth gain practical experience making medical decisions and are empowered to reach certain milestones as outlined below. The individuality of each client and relevant developmental and emotional stages may impact the achievement of these goals.

- ✓ By age 14, the youth should be able to articulate what medications s/he is taking and why, as well as how s/he feels about taking the medication.
- ✓ By age 15, the youth should be able to identify a trusted adult (family member, parent, caregiver, social worker, CASA, mentor, etc.) who they can make aware of their medical needs and who can assist them with their ongoing medical care if necessary. CSW should facilitate a meeting with the youth and the identified adult to discuss and share current medical and mental health information.
- ✓ By age 16, the youth should be aware of when they are to take the medication prescribed, any conditions necessary for them to take the medication as prescribed, and any contraindications relevant to each medication. The youth should be encouraged to share the responsibility with a caregiver or trusted adult to make sure that prescriptions are filled in timely manner and that medication is taken at the prescribed time.

- ✓ By age 17.5, the youth should make medical and mental health appointments and refill prescriptions, initially with the assistance of a caregiver or trusted adult, and later, independently.

- ✓ By age 18, the youth should:

  1. Understand that even if the case is open, s/he will be making decisions about his or her own health and mental health.

  2. Maintain copies of their health and mental health history to include:

     - Contact information for current doctors, therapists psychiatrists and other health professionals
     - Access to their medical history including medications, history of hospitalizations and diagnoses
     - A copy of their DCFS Health and Education Passport

  3. Schedule medical and mental health treatment appointments.

  4. Know any and all medications prescribed, including:

     - The name of the medication(s)
     - The reason it is prescribed
     - The correct dosage
     - Potential side effects
     - Names and contact information for prescribing medical providers

  5. Work with their therapeutic team to revise their treatment plan, as needed, to reflect their treatment decisions as well as to:

     - Understand how to talk with their health care provider about changing or stopping medication
     - Understand the possible side effects of changing or stopping medication
     - Discuss the addition of alternative services to counterbalance the discontinuation of medication.

RESPONSIBILITIES

Children's Law Center of California

1) Collaborate with CSW/PO to ensure that youth have the opportunity to meet the goals/milestones identified above and are receiving the information, support and practice opportunities necessary to be able to do so.

2) Communicate with youth about the significance of consenting to medical treatment.
3) Bring to the court's attention any concerns.

CSW/Probation Officer

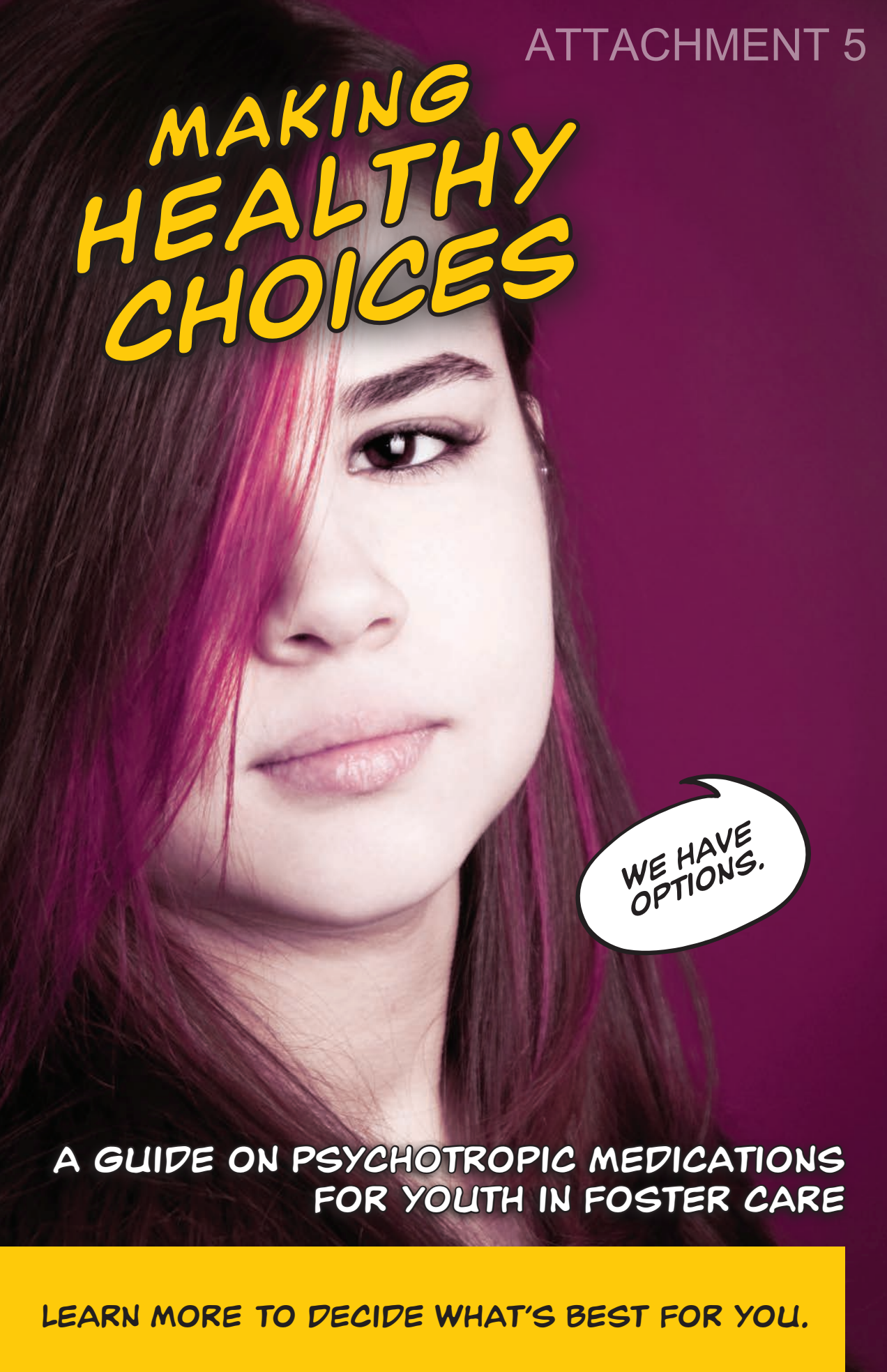
1) Identify goals/milestones in the case plan or TILP.
2) Work with caregiver, trusted adults and/or other relevant individuals (i.e. wraparound, FFA or group home case manager, etc.) to ensure they understand the goals/milestones and what, if any, role they will play in assisting the youth to reach those goals/milestones.
3) Assist youth in working with treating physician to ensure they are receiving the information detailed above.
4) If youth are not meeting the goals/milestones or do not have the information detailed above, provide linkage to adult services, such as regional center, adult mental health & systems of care. Collaborate with adult DMH, regional center workers or medical professionals to identify potential services, placements, etc
5) Inform the court and counsel of the status of the goals/milestones in court reports.

Court

1) Ensure case plan/TILP identifies appropriate goals/milestones, and that youth are receiving assistance to meet such goals/milestones.

ATTACHMENT 5

MAKING HEALTHY CHOICES



A GUIDE ON PSYCHOTROPIC MEDICATIONS FOR YOUTH IN FOSTER CARE

LEARN MORE TO DECIDE WHAT'S BEST FOR YOU.

MAKING HEALTHY CHOICES: A GUIDE ON PSYCHOTROPIC MEDICATIONS FOR YOUTH IN FOSTER CARE

2012

THE CONTENTS OF THIS GUIDE ARE FOR INFORMATIONAL PURPOSES ONLY AND DO NOT SUBSTITUTE FOR PROFESSIONAL MEDICAL ADVICE.

DOING WHAT YOU CAN TO FEEL YOUR BEST

Everyone can benefit from learning what to do to be healthy. Young people in foster care have a lot of stressful things to deal with in their lives. Often they hurt a lot inside. Sometimes their coping skills are overwhelmed. They may need extra help in figuring out how to handle their feelings and improve their health.

Teens who are sad or angry may feel better if they talk to someone they trust, do a favorite hobby, or exercise or play sports. Youth who feel really bad or act in unexpected ways often need help and support from other people. Sometimes, they need therapy and/or medication that can help them control their emotions and behaviors.

When you're hurt, there are often several things you can do to feel better. Imagine you fall and hurt your ankle—you can take a pain reliever, avoid walking on it, and/or apply ice. In the same way, when you hurt a lot inside, you can take medication, avoid activities that make the condition worse, and/or look for positive activities that help you balance your feelings.

WHAT'S IN THIS GUIDE?

Making decisions about your health and psychotropic medications involves several steps, shown in the arrows below. This guide presents valuable information for youth in foster care related to each step. Depending on your situation, selected sections or the entire guide may be useful to you. The guide's checklists and worksheets can help you organize your thoughts.

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PAGE 7

PAGE 10

PAGE 13

PAGE 18

READ ON TO LEARN MORE...

WHY READ THIS GUIDE?

This guide can help you figure out if certain medications are right for you. It was created by a group of youth who have experienced foster care, doctors, social workers, and others who care about young people.

Sometimes your thoughts, emotions, or behaviors get in the way of doing things you want to do. Maybe you're not able to sleep at night or do your homework or have fun with friends. This guide talks about psychotropic medications—one option that may help you feel better. These medications can have many benefits. They also can cause negative side effects and can be harmful if not used correctly. Once you know more, you can decide whether these medications are a good option for you.

WHAT ARE PSYCHOTROPIC MEDICATIONS?

PSYCHOTROPIC (PRONOUNCED "SIKE-OH-TROPE-ICK") MEDICATIONS AFFECT A PERSON'S ***MIND***, ***EMOTIONS***, ***MOODS***, AND ***BEHAVIORS***. DOCTORS PRESCRIBE THESE DRUGS TO HELP PEOPLE FOCUS ON SCHOOL OR WORK AND ENJOY THEIR LIVES MORE.

#1

RECOGNIZING YOU NEED HELP

HOW DO I KNOW IF I NEED HELP?

Young people in foster care are often struggling with past trauma and loss, lots of changes, and issues with family, friends, or their placement. Sometimes, the feelings that result can become overwhelming or even result in depression, anxiety, or stress symptoms that need to be treated with medication.

It's not always easy to know when you should seek help from a doctor, counselor, or teacher. Everyone has bad days from time to time. Most days should not be bad days.

Signs that you may need help include:

- You have symptoms that occur most days.
- You experience a big change in how you feel.
- Your symptoms get in the way of school, your job, or your relationships.
- Your actions are dangerous.

If you see signs that you need help, talk to trusted adults (an advocate, mentor, or caseworker) about getting an appointment with a doctor or mental health specialist.

MICHAEL'S GRADES DROPPED WHEN HE CHANGED SCHOOLS. HE HAD TROUBLE SITTING STILL AND PAYING ATTENTION IN CLASS. FRUSTRATED, HE BEGAN SKIPPING CLASSES. WITH MICHAEL'S INPUT, HIS PLANNING TEAM DEVELOPED A TREATMENT PLAN OF MEDICATION, MEETING WITH A SUPPORT GROUP, AND WRITING IN A JOURNAL. OVER TIME, MICHAEL FELT MORE RELAXED AND COULD FOCUS BETTER IN SCHOOL. HE HAS STARTED WRITING SHORT STORIES AND THINKING ABOUT COLLEGE.

WHAT IS A SYMPTOM?

A SYMPTOM IS SOMETHING YOU EXPERIENCE THAT MAY BE A SIGN OF SOMETHING MORE SERIOUS. FOR EXAMPLE, A TOOTHACHE CAN BE A SYMPTOM OF A CAVITY. THE FOLLOWING MAY BE SYMPTOMS OF DEPRESSION: NOT BEING ABLE TO PAY ATTENTION, LACK OF ENERGY, HEADACHES, AND CONSTANT FEELINGS OF HOPELESSNESS AND SADNESS.

SYMPTOM CHECKLISTS

Use the following checklists to help you record the ways you're feeling and behaving.[1] The symptoms checklists can help organize your concerns to discuss with a doctor or counselor. You also may choose to use the checklists to talk with other people in your life about what you're experiencing and what they've noticed.

Read through each checklist item and think about how often you experience each symptom. While the lists may seem long, they should take only a few minutes to complete. **It's a good idea to bring these checklists with you when you visit your doctor, nurse, or mental health specialist**.

PHYSICAL SYMPTOMS			
	Never	Sometimes	Often
I have headaches			
I have stomachaches			
I get rashes or other skin irritations			
I get tired easily			
I have trouble sleeping			
I sleep too much			
I have problems seeing clearly			
I have problems hearing clearly			
Other:			

	Yes	No
I've recently gained a lot of weight		
I've recently lost a lot of weight		

1 Checklists adapted from *Team Up for Your Child: A Step-by-Step Guide for Working Smarter With Doctors, Schools, Insurers, and Agencies.* (2008). Oak Ridge, TN: Melton Hills Media. Checklists adapted with permission of author Wendy Lowe Besmann.

BEHAVIORS AT SCHOOL, WORK, AND HOME			
	Never	Sometimes	Often
I lose my things (school books, lunch, jewelry, etc.)			
I have trouble getting organized			
I have trouble paying attention			
I have trouble sitting still or doing quiet activities			
I have trouble stopping one activity and starting another activity			
I start many projects without finishing them			
I have difficulty waiting my turn			
I act impulsively (quickly without thinking)			
I argue with people in charge (teachers, bosses, caseworkers)			
I'm afraid to go to school or I skip school			
I talk too much or too fast			
I must follow fixed routines (do things in the same way every time)			
I pull out my hair (from my head or other parts of my body)			
Other:			

	Yes	No
My grades have dropped a lot recently		

SYMPTOMS RELATED TO RELATIONSHIPS			
	Never	Sometimes	Often
I fight with kids my age (peers)			
I have little interest in spending time with friends			
I have trouble making or keeping friends			
Other:			

SYMPTOMS RELATED TO FEELINGS			
	Never	Sometimes	Often
I feel sad or "lost"			
I feel anxious, very worried, or stressed			
I'm easily frustrated			
I get really angry and have outbursts (throw things, yell)			
I blame others for my mistakes or behaviors			
My feelings change very quickly (for example, I'm laughing and happy and then quiet and sad)			
I'm afraid to try new things because I may make mistakes			
I'm really concerned with my weight			
I feel lonely and depressed			
I feel that my life is worthless			
I feel that no one loves me or cares about me			
I think about wanting to die			
Other:			

SYMPTOMS RELATED TO RISKY BEHAVIORS			
	Never	Sometimes	Often
I lie or "con" others to get out of trouble, avoid things, or get things I want			
I've deliberately set fires			
I've been cruel to animals			
I bully or threaten others			
I've hurt others on purpose			
I've used a weapon to harm a person, animal, or property			
I've run away or stayed out all night without permission			
I've committed crimes			
I abuse drugs or alcohol			
I physically hurt myself (cutting)			
I have sex to gain approval from others or to feel better about myself			
Other:			

SEEK IMMEDIATE HELP FROM A DOCTOR, MENTAL HEALTH PROFESSIONAL, OR EMERGENCY ROOM IF:

- YOU'RE THINKING ABOUT HURTING YOURSELF OR ATTEMPTING SUICIDE.
- YOU'RE THINKING ABOUT HURTING SOMEONE ELSE.
- YOU'VE BEEN FEELING DEPRESSED, HOPELESS, OR WORTHLESS FOR SEVERAL DAYS AND HAVE BEEN UNABLE TO TAKE CARE OF YOURSELF.
- YOU'RE HEARING OR SEEING THINGS THAT OTHERS DO NOT HEAR OR SEE.

GETTING A PROFESSIONAL ASSESSMENT

If you are having symptoms that are a problem for you, you should meet with your regular doctor to get the medical help you need. Your doctor will do an assessment that may include asking you a lot of questions, conducting a physical exam, and doing some laboratory work to identify any medical problems. The doctor will then work with you to figure out what might help you feel better.

You and your doctor may decide that it is important to get additional help. For example, sometimes doctors refer patients to a mental health specialist for a full evaluation.

Assessments and evaluations are chances for you to learn more about:

- **Your concerns or symptoms**—Are there reasons for why you feel or behave the way you do?
- **A diagnosis**—Is there a name for what is making you feel or behave the way you do?
- **Recommended treatment**—What does the doctor suggest you do?
- **Options**—Will taking medication help you feel better? What else might help? (Options may include getting help in school, talking with a counselor, or learning strategies for dealing with your feelings and behaviors.)

#2

KNOWING YOUR RIGHTS AND WHO CAN HELP

WHAT ARE MY RIGHTS?

Youth in foster care have legal rights related to health care and medication.

YOU HAVE THE RIGHT TO...

- ☐ **Get a good assessment** in which a doctor or specialist meets with you, listens to you, and discusses options.
- ☐ **Know your diagnosis** and understand the name and nature of what makes you feel and behave the way you do.
- ☐ **Find out all of your options** for treatment, including alternatives to medication. (See page 10.)
- ☐ **Ask questions** about the benefits and side effects of any medication a doctor suggests you take. (See sample questions on pages 14–15.)
- ☐ **Receive support from a planning team** to help you with medical decisions. (See page 8.)
- ☐ **Know who has permission to make decisions** about medications for you. (This may differ according to each State's law.)
- ☐ **Ask an adult you trust for help** in understanding your rights to accept or refuse medication and to ask for changes in your treatment plan.

WHAT IS INFORMED CONSENT?

CONSENT MEANS TO GIVE PERMISSION FOR SOMETHING TO HAPPEN. THROUGH *INFORMED CONSENT*, A DOCTOR PROVIDES INFORMATION ABOUT THE RISKS AND BENEFITS OF A PARTICULAR MEDICATION OR TREATMENT BEFORE PERMISSION IS GIVEN FOR THE MEDICATION TO BE USED. FOR YOUNG PEOPLE WHO ARE NOT IN FOSTER CARE, THEIR PARENTS USUALLY MAKE DECISIONS ABOUT MEDICATION. FOR YOUNG PEOPLE IN FOSTER CARE (OR STATE CARE), EVERY STATE HAS DIFFERENT LAWS AND POLICIES THAT DETERMINE WHO CAN GIVE PERMISSION FOR MEDICATION. AS YOUTH GET OLDER, THEY ARE INCLUDED IN DECISION-MAKING AND GIVING THE "GO AHEAD." (ASK YOUR CASEWORKER ABOUT WHO CAN GIVE CONSENT OR PERMISSION FOR MEDICATION IN YOUR STATE.)

WHO CAN HELP ME MAKE DECISIONS?

You play a key role in decision-making about your health. You're not alone in making health-care decisions. Several people can help you, including those suggested on the worksheet on the next page.

YOUR PLANNING TEAM

A PLANNING TEAM IS A GROUP OF PEOPLE THAT PROVIDE YOU WITH INPUT AND GUIDANCE ON MEDICAL CARE. THE PLANNING TEAM (IF YOU HAVE ONE) MAY INCLUDE YOUR:

- CASEWORKER
- BIRTH PARENTS, SIBLING, OR OTHER FAMILY MEMBERS (IF THEY ARE INVOLVED IN YOUR MEDICAL CARE)
- FOSTER PARENT OR GUARDIAN
- ADVOCATE, MENTOR, OR ANOTHER TRUSTED PERSON OF YOUR CHOICE
- FRIENDS
- ATTORNEY
- GUARDIAN *AD LITEM* (GAL) OR COURT-APPOINTED SPECIAL ADVOCATE (CASA)–PEOPLE ASSIGNED BY A JUDGE TO LOOK OUT FOR YOUR BEST INTERESTS WHILE IN FOSTER CARE
- DOCTOR, NURSE, OR OTHER MEDICAL PROVIDER WHO HELPS WITH PHYSICAL HEALTH CARE
- HEALTH- OR MENTAL HEALTH-CARE PROVIDER WHO PRESCRIBES MEDICATIONS TO HELP BALANCE MOODS AND BEHAVIORS

WORKSHEET ON WHO CAN HELP MAKE DECISIONS

Fill in the table with names of people you feel you can talk to for support and guidance.

Caseworker	
Name	
Phone	
Email	
Birth parent, sibling, or other family members	
Name	Name
Phone	Phone
Email	Email
Foster parent or guardian	
Name	
Phone	
Email	
Advocate, mentor, or another trusted person of your choice	
Name	
Phone	
Email	
Friend	
Name	
Phone	
Email	
Attorney, guardian *ad litem* (GAL), or court-appointed special advocate (CASA)	
Name	
Phone	
Email	
Doctor, nurse, or other medical professional who helps with physical health care	
Name	Name
Phone	Phone
Email	Email
Health- or mental health-care provider who prescribes medications to help balance moods and behaviors	
Name	
Phone	
Email	

#3 CONSIDERING YOUR OPTIONS

WHAT ARE MY OPTIONS?

Your doctor or mental health specialist may discuss several options with you. These options may include:

Helpful approaches other than medication

Psychotropic medication for temporary or long-term use

A combination of the above

OPTIONS OTHER THAN MEDICATION

Sometimes there are treatments that can be used instead of or in addition to medication.

- **Counseling/therapy.** It's always good to have trusted friends and family to talk with about your problems. Sometimes that's not enough. In those cases, you may want to talk with a trained therapist who can listen and offer guidance. The therapist can help you learn useful ways to deal with your feelings. An adult on your planning team can help you find a therapist.
- **Meditation.** Meditation is a type of mental exercise in which you learn to relax your body and calm your mind. Meditation is known to reduce stress and can help improve concentration. It can bring inner peace by helping you control your thoughts and become more aware. Meditation is a skill that requires learning and practice. A workshop or class can help get you started.
- **Exercise.** Exercise releases endorphins, or "feel-good" chemicals, in your brain. These chemicals make you feel less sad or anxious. Being active can take your mind off your problems and improve your ability to deal with things. You can exercise alone, join a team, or organize some friends. Look for physical activities that you enjoy—hiking, dance, basketball, or other—and make exercise fun.

- **Diet.** What you eat may affect your moods and energy levels. You may feel better eating less "bad carbs," including foods with lots of sugar or white flour (muffins, white bread, bagels). Research tells us to eat foods rich in healthy omega-3 fats, which can be found in nuts and certain fish (tuna, salmon). Vitamins and minerals also can help your brain and body work better. Before taking vitamin supplements or making changes in your diet, talk with your doctor.
- **Other activities.** There may be other ways to help you feel better, such as:
  - Keeping a journal of what's going on in your life and how you feel about things
  - Drawing, painting, or other art work
  - Joining a club
  - Participating in a support group of other youth in similar situations
  - Volunteering and helping others

AFTER BEING SEPARATED FROM HIS MOTHER AND LITTLE BROTHER, TONY LASHED OUT AT THOSE AROUND HIM. HIS MIND WAS RACING ON OVERDRIVE. AFTER TALKING WITH HIS DOCTOR AND A YOUTH COUNSELOR, HE DECIDED MEDICATION WASN'T FOR HIM. INSTEAD, HE STARTED MEETING REGULARLY WITH A THERAPIST, WHO HELPED HIM SORT THROUGH HIS ANGER. JOINING THE SCHOOL'S FOOTBALL TEAM ALSO HELPED CHANNEL HIS ENERGIES.

PSYCHOTROPIC MEDICATIONS

Psychotropic medications can help people be healthy. Some medications may affect how you feel, and some may change behaviors that get in the way of your well-being. They can help you focus on things you want to do—like staying in school, holding a job, and enjoying time with friends. They may help you feel more in control and more satisfied with your life.

Doctors prescribe these medications to reduce symptoms such as anxiety, difficulties paying attention, and racing thoughts. They also are used to treat conditions including attention-deficit hyperactivity disorder (ADHD), depression, psychotic disorders, and others.

While psychotropic medications can have many benefits, they also may have side effects. Side effects are unwanted changes that occur in addition to the intended positive effects. Side effects vary from medication to medication and person to person. Some possible side effects of psychotropic medications include sleepiness, stomach upset, headaches, nervousness, irritability, and weight gain. Often, side effects will go away within a few weeks. You may decide that it's worth putting up with side effects, if the benefits outweigh them.

There is a risk of medications causing harm if not used correctly. Safe use of psychotropic medications is discussed in the section on maintaining treatment (page 18).

ANITA THOUGHT MOVING IN WITH HER GRANDMOTHER WOULD MAKE HER LIFE BETTER, BUT SHE STILL FELT WORRIED ALL THE TIME. SOME DAYS, IT SEEMED DIFFICULT JUST TO BREATHE. SCARED HER FRIENDS WOULDN'T UNDERSTAND, SHE BEGAN TO AVOID THEM. ON THE ADVICE OF HER DOCTOR, SHE FOUND A MEDICATION THAT HELPED HER FEEL BETTER. SOON, IT WAS EASIER TO MAKE IT THROUGH THE DAY. SHE BEGAN LOOKING FORWARD TO HAVING FUN WITH HER FRIENDS AGAIN. OVER TIME, HER DOCTOR HELPED HER TO GRADUALLY STOP TAKING THE MEDICATION AND IDENTIFY OTHER WAYS TO DEAL WITH HER ANXIETY.

#4 MAKING YOUR DECISION

WHAT INFORMATION DO I NEED?

There is a lot of information you should have before taking medication. Below is a list of questions to help guide you in making decisions about how best to stay healthy. You may have more questions than you see here.

Take these questions with you when you talk about your health with the adults in your life. Remember, answers to these questions and your decisions may change over time.

QUESTIONS TO ASK YOURSELF
...ABOUT BEING HEALTHY:

- ☐ What are some things that I could do to be healthy? (For example, change my diet, get more sleep, see a counselor, take medication)
- ☐ What do I already know about how each option (including medication) might help me? How might they harm me?
- ☐ How long would I need to do each of these things?
- ☐ How will I know when I'm healthy?
- ☐ Who can help me make the right decision for me?

QUESTIONS YOU MAY ASK AN ADVOCATE, MENTOR, OR OTHER ADULT
...ABOUT YOUR RIGHTS:

- ☐ Who has the right to make decisions about my taking medication?
- ☐ Can a decision be made without me saying what I want? If that happens, what right do I have to speak to the person who made the decision (such as the judge or caseworker)?
- ☐ Do I have a right to refuse to take medication?
- ☐ If I refuse to take medication, what will happen? Can I be punished? Can I be asked to leave my placement?

CONTINUED...

- ☐ If I disagree with a decision about medication or my medical care, what can I do or who can I call? Should I speak with my attorney or guardian *ad litem*?
- ☐ Does my State have someone, such as an ombudsman (pronounced om-budz-man), who investigates complaints and helps youth in foster care?
- ☐ If I disagree with a decision about medication, do I have the right to get a second opinion from another doctor? How do I get a second opinion?
- ☐ Who else should know that I'm taking medication? What do they need to know and why?
- ☐ Who will find out that I've taken this medication? Can it make it harder to get a job or join the military if I take this medication?
- ☐ Can I see my medical records? Can I have a copy?
- ☐ Who pays for my health-care expenses while in foster care?
- ☐ How will I pay for health-care expenses when I leave foster care? Who can help me with medication decisions and payments once I leave care?

QUESTIONS TO ASK YOUR DOCTOR

...ABOUT GENERAL INFORMATION ABOUT A MEDICATION:

- ☐ What is my diagnosis?
- ☐ Do you recommend medication? What is the name of the medication you recommend?
- ☐ How much do I have to take and how often? (this is called "dosage")
- ☐ How long will I have to take the medication?
- ☐ How will I know it is working? When will it start working?
- ☐ How common is it for people my age to be on this medication?
- ☐ How much experience do you have with this medication?

...ABOUT HOW THE MEDICATION MAY CHANGE YOUR LIFE:

- ☐ How will this medication make me feel?
- ☐ How will using this medication change the way I act at school? How will it change the way I act or feel around family or friends?
- ☐ How can this medication help me achieve my goals in life?

...ABOUT THE SIDE EFFECTS OF THE MEDICATION:

- ☐ How might this medication harm me?
- ☐ What are the medication's side effects? How long do side effects typically last?
- ☐ Will the medication cause me to gain weight? Will I lose weight? Is there anything I can do to keep my current weight while taking the medication?
- ☐ Is this medication addictive (hard to give up once started)?
- ☐ What are the effects if the medication is taken with alcohol, marijuana, or other drugs?

...ABOUT USING THE MEDICATION SAFELY:

- ☐ What do I do if a problem develops (I get sick, I miss taking the medication, or I get side effects)?
- ☐ Are there foods I should avoid while on the medication? Are there special things I should or should not do while taking the medication?
- ☐ Will I need blood work or other kinds of medical tests before, during, or after treatment? What will the doctor look for?
- ☐ What do I do if I start taking the medication and then decide I don't like it? Who do I talk to?
- ☐ If I want to, can I just stop taking the medication?
- ☐ How often should I see the doctor (or other person) who prescribed the medication?
- ☐ Who will help me keep track of how the medication is working for me? How will changes be monitored?
- ☐ Who can I talk to about medication other than my doctor? Who needs to know I'm on this medication and why?

...ABOUT ALTERNATIVES AND OPTIONS:

- ☐ What other medications might help me?
- ☐ What alternatives to medication (meditation, changes in diet, exercise, etc.) might help me?
- ☐ Should I try other things that might help me at the same time as the medication?

WHAT ARE THE RISKS AND BENEFITS?

Based on what you've learned, you can use this worksheet to write down the pros (benefits) and cons (negatives) of taking medication.[2] You can discuss your hopes and concerns for this medication with adults who are helping you make your decision.

PROS AND CONS WORKSHEET

If I DO take the medication—*What does my doctor (or other decision-making supports) say about taking the medication*?

Pros/Benefits	Cons/Side Effects

If I DON'T take the medication—*What does my doctor (or other decision-making supports) say about NOT taking the medication*?

Pros/Benefits	Cons/Side Effects

2 Adapted from *Making a Choice: A Guide to Making A Decision About Using Antipsychotic Medication* by Youth MOVE Maine (http://www.youthmovemaine.org), Maine's Youth Leadership Advisory Team (http://www.ylat.org), and Maine Department of Health and Human Services. Available from http://www.ylat.org/rights/medication.pdf.

WILL MEDICATION HELP ME REACH MY PERSONAL GOALS?

You may want to think about how medication might help you achieve your life goals.[3] For example, if your goal is to go to college, medication may help you to concentrate in school and improve your grades. In some cases, medication or medication side effects may make it harder to reach your goals. Share your goals with your doctor so he/she understands what you want to achieve.

GOALS WORKSHEET
Use this worksheet to write about your goals—things you want to achieve in life.
In the next 3 months, my goals are to:
In the next 2 years, my goals are to:
If I could look into a crystal ball and see myself 5 years from now, what do I hope for?
How could medication help me reach my goals?
How might medication or medication side effects create challenges for reaching my goals?

3 Adapted from *Making a Choice: A Guide to Making A Decision About Using Antipsychotic Medication* by Youth MOVE Maine (http://www.youthmovemaine.org), Maine's Youth Leadership Advisory Team (http://www.ylat.org), and Maine Department of Health and Human Services. Available from http://www.ylat.org/rights/medication.pdf.

#5 MAINTAINING TREATMENT

HOW DO I MAKE SURE I'M TAKING MY MEDICATION SAFELY?

To increase the benefits and reduce the risks of using psychotropic medication, you need to be an active member of your health-care team.

It is important to:

- **Ask questions.** Talk with your doctor, nurse, pharmacist, and other health-care providers about your medications. Know what each medication is for, how to take it, what kinds of side effects to expect, and what actions might help reduce the side effects. (See sample questions beginning on page 14.)
- **Follow the directions on the label.** Take the medication exactly as prescribed.
- **Learn about what things don't mix well with your medication.** Some medicines, foods, and drinks should not be taken together. When mixed, they may reduce the positive effects of your medication or cause harmful effects. For example, drinking alcohol while taking medication can slow your reactions and make driving a car dangerous. Some herbs and supplements can interact with prescription medications in unsafe ways. Also, some medical conditions (such as high blood pressure) can cause unwanted reactions with certain medications. Talk with your doctor or pharmacist and read medication labels to learn more about what you should avoid when taking your medication.
- **Keep records.** Make an up-to-date list—on paper or your phone—of ALL medicines (prescription and over-the-counter) that you take, as well as vitamins, herbs, and other supplements. Make notes on how each medication makes you feel, side effects, and changes over time.
- **Follow up with your doctor regularly.** Throughout the time you are taking your medication, your doctor(s) should follow up with you, listen to your concerns, and monitor your progress.

DO NOT SHARE YOUR MEDS!

YOUR PSYCHOTROPIC MEDICATION IS INTENDED TO BE USED BY YOU AND ONLY YOU. GIVING YOUR MEDICATION TO SOMEONE ELSE COULD RESULT IN SERIOUS SIDE EFFECTS AND EVEN DEATH.

PREVENT BREAKS IN YOUR MEDICATION.

TIP: DON'T WAIT UNTIL YOU RUN OUT OF MEDICATION BEFORE YOU ASK FOR A REFILL. ADD A REMINDER TO YOUR CALENDAR OR PHONE TO CHECK YOUR SUPPLY AND CALL FOR A REFILL. IN SOME CASES, YOU MAY BE REQUIRED TO HAVE A DOCTOR'S APPOINTMENT IN ORDER TO GET A REFILL.

WHAT IF I WANT TO STOP TREATMENT?

Always talk with your doctor if you are thinking about stopping your medicine. You and your doctor should make this very important decision together. When you suddenly stop taking certain medications, you may experience uncomfortable or harmful side effects. These medicines have to be decreased slowly over several weeks. When you and your doctor agree that it is time to stop a medication, it is very important that you follow your doctor's instructions about how to do this.

Get rid of unused medication carefully. Make sure that other people and animals can't take and be harmed by leftover pills.

For more information, read *Disposal of Unused Medicines: What You Should Know*. http://www.fda.gov/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/EnsuringSafeUseofMedicine/SafeDisposalofMedicines/ucm186187.htm

SONYA DIDN'T LIKE HOW HER MEDICATION MADE HER FEEL TIRED AND UNABLE TO CONCENTRATE. SHE WANTED TO STOP TAKING IT. INSTEAD, SHE MET WITH HER DOCTOR AND TALKED ABOUT CHANGING TO A NEW MEDICINE THAT DIDN'T HAVE THE SAME SIDE EFFECTS.

WHAT SHOULD I DO ABOUT MEDICATION WHEN I'M LEAVING FOSTER CARE?

If you're getting ready to leave foster care, there are a few important things for you to do:

1. **Meet with your caseworker to develop a plan.** The law requires your caseworker to meet with you at least 90 days before you turn 18 (or before you are scheduled to leave foster care) to develop a transition plan. The plan should discuss ways to meet your needs for:

   - Lifelong connections to caring and supportive adults
   - Mental health and medical services
   - Health-care insurance coverage
   - Housing
   - Education
   - Employment

   You have the right to invite a mentor or other trusted adults to this meeting to help develop a plan that best meets your needs.

2. **Think about whether you want to continue your medication.** At the meeting with your caseworker and other trusted adults, discuss your wishes and concerns. Find out what your doctor(s) recommend.

   - **If you want to continue taking your medication:**
     Talk to your caseworker before leaving foster care about who can help you get and pay for future medication.
   - **If you want to stop taking your medication:**
     Talk to your doctor about how to decrease the dosage gradually.

3. **Get a copy of your medical records.** You should receive a free copy of your medical records. This is required by law when you're leaving foster care at 18 (or the age of majority in your State.) You may need some information from these records for future health care and also for college and job applications.

   Make sure your medical records include information on:

   - The name(s) of your doctor(s) and other health-care providers
   - Major illnesses, medical conditions, and injuries and the services provided to address them
   - Medications taken (psychotropic and others), when taken, when stopped, and why
   - Undesirable reactions to medication (if applicable)
   - Allergies
   - Immunizations
   - Growth records
   - Biological family history of major medical conditions (if known)

4. **Look into health insurance.** Health care can be expensive. There are some ways to get free or low-cost health care, including:

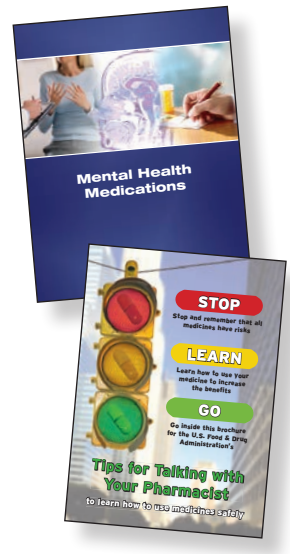
   - **Medicaid.** Many States offer continued health insurance for former foster youth through the Medicaid program. (Note: Medicaid coverage is only available until you reach a certain age, often 19 or 21.) To get continued health insurance, you often have to **make arrangements before you leave foster care**. Work together with your caseworker (or other adult) to complete the necessary paperwork. Make sure you find out what you will need to do on your own to continue coverage.
   - **Community health centers.** Federally funded health centers care for you, even if you have no health insurance. You pay what you can afford, based on your income. You can find a health center near you on the web at http://findahealthcenter.hrsa.gov.
   - **Student health centers.** If you're in college, you may be able to access health care through your school's student health center.

   Talk about these and other options with your caseworker.

NOW WHAT?

LEARNING MORE IS AN IMPORTANT FIRST STEP. CONTINUE TO ASK QUESTIONS AND TALK WITH YOUR DOCTOR(S) AND OTHER TRUSTED ADULTS. TOGETHER, YOU CAN FIGURE OUT WHAT MAKES THE MOST SENSE FOR A HEALTHY YOU.

To learn more about possible side effects and taking your medication safely, read the following online publications:



- *Mental Health Medications*. National Institute of Mental Health. http://mentalhealth.gov/health/publications/mental-health-medications/complete-index.shtml
- *Stop—Learn—Go. Tips for Talking With Your Pharmacist to Learn How to Use Medications Safely.* U.S. Food and Drug Administration. http://www.fda.gov/Drugs/ResourcesForYou/ucm163330.htm

WHAT DID I LEARN? WHAT ELSE DO I NEED TO KNOW?

Use this space to make notes that will help you think through your decisions about taking medication and other options to improve your health.

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- Children's Bureau, U.S. Department of Health and Human Services
- Administration for Children and Families, U.S. Department of Health and Human Services
- American Academy of Child and Adolescent Psychiatry
- American Academy of Pediatrics
- Food and Drug Administration, U.S. Department of Health and Human Services
- Jim Casey Youth Opportunities Initiative
- Maine Department of Health and Human Services
- Maine Youth Leadership Advisory Team
- National Resource Center for Youth Development
- Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services
- Tufts Medical Center
- Youth MOVE Maine

The contents of this publication do not necessarily reflect the views, opinions, or policies of these agencies.

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Children's Bureau

U.S. Department of Health and Human Services
Administration for Children and Families
Administration on Children, Youth and Families
Children's Bureau
http://www.acf.hhs.gov/programs/cb

Psychotropic Medication Youth Engagement Worksheet

	YES	NO	COMMENTS (as needed)
1. Does the youth know the name of the medication(s) being taken?	☐	☐	
2. Does the youth know the reason for the medication(s)?	☐	☐	
3. Does the youth know his or her diagnosis?	☐	☐	
4. Does the youth know the dosage(s)?	☐	☐	
5. Is the youth aware of the potential side effects?	☐	☐	
6. Does the youth know the medication schedule?	☐	☐	
7. Does the youth self-administer the meds?	☐	☐	
8. Does the youth know the prescribing physician's name and contact information?	☐	☐	
9. Does the youth know how to make an appointment with the prescribing physician?	☐	☐	
10. Does the youth understand the danger of stopping the meds without consulting the prescribing physician?	☐	☐	
11. Does the youth have medical coverage?	☐	☐	
12. Does the youth know how to use the medical coverage?	☐	☐	
13. Does the youth know how and where to refill medical prescriptions?	☐	☐	
14. Does the youth have copies of his/her medical records and history?	☐	☐	
15. Does the youth have a trusted adult to talk with about medical issues?	☐	☐	
16. Does the youth have contact information for the designated consulting public health nurse (PHN)?	☐	☐	

Name of Youth _____ Case Number _____ ☐ DCFS ☐ Probation

Name of Preparer _____ Agency _____ Date Prepared _____