

Models of Agency Consent for Psychotropic Medications

Because children and youth in foster care are prescribed psychotropic medications at a higher rate than other children in Medicaid,¹ an effective consent process is essential to ensuring that these children are receiving appropriate treatment and monitoring. State consent policies for psychotropic medications for children and youth in foster care vary in many ways, including who serves as the consenting entity, the timeframe of the consent, whether youth assent is required or preferred, and whether there are instances when prescribing may occur without consent. In a number of states, when a child is placed in foster care, an agent of the state (e.g., a regional behavioral health administrator or child welfare director) is granted authority to provide consent for the child's psychotropic medication prescriptions.

This fact sheet is one in a series of resources from the *Psychotropic Medications Virtual Learning Community*, a collaborative learning platform for state behavioral health, child welfare, and Medicaid leaders. The platform includes webinars and opportunities for peer-to-peer exchange between states working to reduce inappropriate psychotropic medication use among children and youth in foster care through improved oversight and monitoring.

What is agency consent?

Agency consent is an oversight model that requires child welfare agencies to conduct a secondary review of psychotropic medications prescribed to children and youth in child welfare. The process helps to prevent the inappropriate prescribing of psychotropic medications to these children and youth.

How is it done?

States vary considerably in how agency requirements for consent are implemented, but there are generally three models: (1) decentralized; (2) centralized internal; and (3) centralized external. In a decentralized agency consent model, the review of a psychotropic medication prescription is done by a clinical professional, with review assignment determined based on the region in which a child is located. In a centralized internal agency consent model, reviews of all prescriptions for psychotropic medications for children in foster care are conducted by staff within the child welfare or other child-serving agency. Through a centralized external agency consent model, a state may contract with an external entity, such as an academic medical center, to perform the review of psychotropic medications. Following are state examples of each model type.

State Agency Consent Models



Decentralized Agency Consent – New Jersey

New Jersey's Department of Children and Families' (DCF) Case Practice Model recognizes the important role of parents in a child's ongoing care. Because a significant number of children are reunified with their parents, DCF works to ensure that parents whose rights have not been terminated are involved in the decision-making process and requires their consent for psychotropic medication and other non-routine medical treatment. The Division of Child Protection and Permanency (CP&P) local office manager or designee may provide consent under limited circumstances, including when parental rights have been terminated, a court has provided specific authority to CP&P, or in an emergency if the parents are unavailable. The DCF preference for decentralized decision-making is made possible by Child Health Units (CHUs) co-located in each of the state's local child welfare offices and by access to child/adolescent psychiatrists or other appropriate medical professionals. CHUs are staffed with bachelor-prepared nurses who serve as Health Care Case Managers (HCCMs) for children in foster care and staff assistants. When a child is prescribed psychotropic medication, the CP&P caseworker and CHU HCCM work with the treating professional to gather all relevant health information to help the parent and/or CP&P make the most informed decision. The CHU HCCMs are available to answer general questions about psychotropic medications and review the NJ DCF Psychotropic Medication Policy Prescribing Parameters for specific medications. However, most questions about the treatment are directed to the prescriber. When the parent, CP&P, and/or the HCCM have additional concerns, they can consult with DCF's child/adolescent psychiatrists. Cases commonly referred for consultation include children under age six prescribed medication not recommended per prescribing parameters; children prescribed three or more psychotropic medications; children with complicating medical illness; and children prescribed medication not approved for their diagnosis.

This is one in a set of psychotropic medications fact sheets produced with support from the Annie E. Casey Foundation. For more information, visit www.chcs.org.



Centralized Internal Agency Consent – Connecticut

Connecticut's Department of Children and Families (DCF) is responsible for providing child welfare, behavioral health, juvenile justice, education, and prevention services. Housed within DCF is the Centralized Medication Consent Unit (CMCU) that oversees psychotropic medication prescribing for children and youth served by DCF. Led by a chief of psychiatry and staffed with two child psychiatrists and an advanced practice nurse, the CMCU both facilitates the consent process, and analyzes prescribing patterns, tracking indicators like utilization trends and outlier prescribing. After a provider submits a consent form to the CMCU, a staff psychiatrist or the advanced practice nurse reviews the Statewide Automated Child Welfare Information System (SACWIS) for the child's treatment history and other information to inform the consent decision. If approval is given, staff from the CMCU enter the new prescription information into SACWIS and email the child welfare case worker, regional nurse, and regional clinical manager regarding the treatment decision. Connecticut's approach to agency consent is well-regarded by providers, since it uses a standardized and centralized approach that allows for quick turn-around.



Centralized External Agency Consent – Illinois

Illinois' Department of Children and Family Services (DCFS) first contracted with the University of Illinois to provide independent medication review in 1992, as the result of court-mandated child welfare reforms. A component of the contract, the University's Clinical Services in Psychopharmacology (CSP) unit is staffed by a child psychiatrist, psychiatric nurses, research assistants, a full-time programmer, and other staff. The CSP provides an independent review of all psychotropic medication requests, monitors psychotropic medication use, notifies DCFS' authorized consenting agent when provider patterns warrant review, and makes recommendations to the DCFS agent, who makes the consent decision. To receive consent, a provider must supply the CSP with demographic information, clinical information (e.g., diagnosis, current medications, laboratory tests), and the medication request (e.g., type of request – new, renewal, emergency; dose, range, and duration; symptoms; rationale for poly-pharmacy). The CSP captures this information in its consent database, which is used to track utilization trends, monitor outlier prescribing, and regularly review high-risk children and youth. Quarterly reports are reviewed to evaluate a number of factors, including medications prescribed to children under four years of age, instances of poly-pharmacy, and medications prescribed without consent. In addition to its formalized review of data, the clinical staff at CSP regularly consult with prescribers to help guide decisions around prescribing medications and other treatment for children and youth in foster care. For Illinois, the CSP's centralized system provides the state with a rich source of information on children and youth involved in child welfare.

Conclusion

A large number of children and youth in foster care are prescribed psychotropic medications, and these medications are often prescribed by primary care providers. A strategic agency consent process can help ensure that clinicians with psychiatric expertise have input regarding the appropriateness of proposed psychotropic medication treatments. States with existing agency consent models vary in terms of who provides consent; whether psychiatric support comes from an internal government agency or from an external source; whether psychiatric support is provided from a centralized unit or is provided in a more decentralized way, as well as along other dimensions. A state's decision to implement an agency consent process and the structure of this process depend on multiple factors, including the availability of psychiatric resources, internal state staffing capacity, and funding mechanisms. Regardless of how it is provided, a strong agency consent process can be an effective tool in a state's oversight and monitoring of psychotropic medication use.

¹ S. Pires, K. Grimes, K. Allen, T. Gilmer, and R. Mahadevan. "Faces of Medicaid: Examining Children's Behavioral Health Service Utilization and Expenditures." Center for Health Care Strategies, December 2013.