California State Auditor

August 2016

California's Foster Care System

The State and Counties Have Failed to Adequately Oversee the Prescription of Psychotropic Medications to Children in Foster Care

Report 2015-131

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California State Auditor

Elaine M. Howle State Auditor
Doug Cordiner Chief Deputy

August 23, 2016 2015-131

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee, the California State Auditor presents this audit report concerning the oversight of psychotropic medications prescribed to California's foster children. This report concludes that the State and counties have failed to adequately oversee the prescribing of these medications. Specifically, some counties have yet to adopt the State's prescribing guidelines (state guidelines), a valuable tool that counties should use to ensure that foster children do not receive inappropriate or unnecessary psychotropic medications. Consequently, when we reviewed the case files for a total of 80 foster children at Los Angeles, Madera, Riverside, and Sonoma counties, we found that many foster children were authorized psychotropic medications in quantities and dosages that exceeded the state guidelines. Although exceeding the state guidelines may be medically appropriate in some cases, we found no evidence that the counties had followed up with the health care providers to ensure the safety and necessity of the medications. When counties do not follow up with providers about prescriptions that exceed the state guidelines, the counties cannot ensure that they are reducing foster children's exposure to potentially inappropriate medication interventions.

Further, the counties have not always ensured that they follow best practices relating to the health services that foster children should receive in conjunction with their psychotropic medications. Specifically, one-third of the foster children whose records we reviewed did not receive follow-up appointments with their prescribers or other healthcare providers within 30 days after they began taking new psychotropic medications, thus increasing the risk that any harmful side effects would go unaddressed. Further, our review of the 80 case files indicates that foster children did not always receive corresponding psychosocial services before or while they were taking psychotropic medications. Additionally, and in violation of state law, counties did not always obtain required court authorizations or parental consents before foster children received prescriptions for psychotropic medications.

Finally, we found that the fragmented structure of the State's child welfare system contributes to the problems we identified. Oversight of psychotropic medications prescribed to foster children is vested among different levels and branches of government, leaving us unable to identify a comprehensive plan that coordinates the various mechanisms in place. Although the different public entities involved have made efforts to collaborate, the State's overall approach has exerted little system-level oversight to help ensure that these entities' collective efforts actually work as intended and produce desirable results. For instance, the fragmented oversight structure has contributed to the State's failure to ensure it and other stakeholders have the reliable information necessary to monitor the prescription of psychotropic medications to foster children. Even when combined, the results from data systems operated by two state departments still contain inaccurate and incomplete data related to foster children who are prescribed psychotropic medications. Consequently, neither of the two departments can completely identify which foster children statewide are prescribed psychotropic medications or which medications those children are prescribed. We recommend that the State collaborate with counties and other stakeholders to develop and implement a reasonable oversight structure for psychotropic medications prescribed to foster children.

Respectfully submitted,

Elaine M. Howle

ELAINE M. HOWLE, CPA
State Auditor

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Summary

Results in Brief

Psychotropic medications such as antidepressants, mood stabilizers, and antipsychotics can provide significant benefits in the treatment of psychiatric illnesses, but they can also cause serious adverse side effects. Although the American Psychological Association has mentioned that studies since the 1970s have found that children in foster care (foster children) often have a greater need for mental health treatment, public and private entities have expressed concerns about the higher prescription rates of psychotropic medication among foster children than among nonfoster children. This issue is of particular importance to California, which has the largest population of foster children in the country. In fact, our analysis of the available state data found that nearly 12 percent of California's more than 79,000 foster children were prescribed psychotropic medications during fiscal year 2014–15, whereas studies suggest that only about 4 to 10 percent of nonfoster children are prescribed these medications.

To examine the oversight of psychotropic medications prescribed to foster children, we reviewed case files for a total of 80 foster children in Los Angeles, Madera, Riverside, and Sonoma counties and analyzed available statewide data. We found that many foster children had been authorized to receive psychotropic medications in amounts and dosages that exceeded the State's recommended guidelines (state guidelines), circumstances that should have prompted the counties responsible for their care to follow up with the children's prescribers. For example, 11 of the 80 children whose files we reviewed had been authorized to take multiple psychotropic medications within the same drug class. Further, 18 of the 80 children had been authorized to take psychotropic medications in dosages that exceeded the State's recommended maximum limits. Medications that exceed the State's recommended guidelines may be appropriate under some circumstances, and we are not questioning prescribers' medical expertise. However, in the instances above, the counties did not contact the prescribers to ensure the safety and necessity of the medications in question, as the state guidelines recommend.

Compounding these concerns is the fact that many of these children do not appear to have received follow-up visits or recommended psychosocial services in conjunction with their prescriptions for psychotropic medications. The American Academy of Child and Adolescent Psychiatry recommends that children should receive follow-up visits with their health care providers ideally within two weeks, but at least within a month, after they start psychotropic medications. Nonetheless, one-third of the 67 foster children who started at least one psychotropic medication during our audit period did not receive follow-up appointments with their prescriber or

Audit Highlights . . .

Our audit concerning the oversight of psychotropic medications prescribed to California's foster children revealed the following:

- *Nearly 12 percent of California's more than 79,000 foster children were prescribed psychotropic medications during fiscal year 2014–15.*
- *Some foster children were prescribed psychotropic medications in amounts and dosages that exceeded state guidelines and counties did not follow up with prescribers to ensure the appropriateness of these prescriptions.*
- *Many foster children did not receive follow-up visits or recommended psychosocial services in conjunction with their prescriptions for psychotropic medications.*
- *Counties did not always obtain required court or parental approval for psychotropic medications prescribed to foster children as required by law.*
- *The State's fragmented oversight structure of its child welfare system has contributed to weaknesses in the monitoring of foster children's psychotropic medications.*
- *The California Department of Social Services' and the Department of Health Care Services' data systems together cannot completely identify which foster children are prescribed psychotropic medications.*
- *Foster children's Health and Education Passports—documents summarizing critical health and education information—contained inaccurate and incomplete mental health data.*

other health care provider within 30 days after they began taking new psychotropic medications, thus increasing the risk that any harmful side effects would go unaddressed. In addition, our review of the 80 case files indicates that foster children did not always receive corresponding psychosocial services before or while they were taking psychotropic medications, even though such services are critical components of most comprehensive treatment plans.

In response to a recent state law, the Judicial Council of California adopted new and revised forms—which became effective in July 2016—to be used in the court authorization process for foster children's psychotropic medications. The proper completion of these newly revised forms should provide county staff with additional information necessary to identify instances when foster children are prescribed psychotropic medications in amounts or dosages that exceed the state guidelines. Among other things, these revised forms require prescribers to explain for each foster child why they prescribed more than one psychotropic medication in a class or dosages that are outside the state guidelines. If these forms are not properly completed, county staff will need to follow up with prescribers to obtain information necessary to ensure that the prescriptions beyond the state guidelines are appropriate.

We also found that, in violation of state law, counties did not always obtain required court or parental approval before foster children received prescriptions for psychotropic medications. Specifically, when we reviewed the case files for 67 foster children who should not have received psychotropic medications without authorization from a juvenile court, we found that 23 (34 percent) did not contain evidence of such authorization for at least one psychotropic medication. Similarly, when we reviewed the case files for 13 foster children who should not have received psychotropic medications without the consent of their parents, we found that five (38 percent) did not contain evidence of such consent for at least one psychotropic medication. In effect, these children were prescribed psychotropic medications without proper oversight from the counties responsible for their care.

Further, the fragmented structure of the State's child welfare system contributed both to the specific problems we identified in our review of the 80 case files and to larger oversight deficiencies that we noted statewide. Specifically, oversight of the administration of psychotropic medications to foster children is spread among different levels and branches of government, leaving us unable to identify a comprehensive plan that coordinates the various mechanisms currently in place to ensure that the foster children's health care providers prescribe these medications appropriately. Although the different public entities involved have made efforts

to collaborate, the State's overall approach has exerted little system-level oversight to help ensure that these entities' collective efforts actually work as intended and produce desirable results.

The State's fragmented oversight structure has also contributed to its failure to ensure it has the data necessary to monitor the prescription of psychotropic medications to foster children. The two state entities most directly involved in overseeing foster children's mental health care are the California Department of Social Services (Social Services) and the Department of Health Care Services (Health Care Services). Even when combined, results from data systems these two departments operate still contain inaccurate and incomplete data related to foster children who are prescribed psychotropic medications. Consequently, neither agency can completely identify which foster children statewide are prescribed psychotropic medications or which medications those children are prescribed.

Further, the inaccurate and incomplete information in Social Services' data system is used to produce Health and Education Passports, which are critical documents that are meant to follow foster children should their placement change. We found that all 80 of the Health and Education Passports we reviewed contained instances of incorrect start dates for psychotropic medications. Moreover, 13 of these 80 Health and Education Passports did not identify all the psychotropic medications that the courts authorized, and all 80 were missing information about the corresponding psychosocial services the foster children should have received for at least one psychotropic medication. These errors and omissions appear to have been caused in large part by a lack of county staff to enter foster children's health information into Social Services' data system and an unwillingness of some county departments to share foster children's information with each other. However, caretakers, health care providers, social workers, and others rely on the Health and Education Passports to make decisions about foster children's care; without accurate information, they may inadvertently make decisions that do not reflect the children's best interests.

Also, the State has missed opportunities to ensure that the counties have reasonable processes for overseeing the prescription of psychotropic medications to foster children. For example, Social Services' California Child and Family Services Reviews of the counties only recently began examining in more depth psychotropic medications prescribed to foster children. Because Social Services and Health Care Services have not historically examined the prescription of psychotropic medications to foster children in their periodic reviews, they have missed opportunities for in-depth, county-by-county reviews of this issue. However, as of March 2016, both departments had begun collecting from the counties certain information about these medications.

Finally, rather than publishing this audit report in June 2016 as originally intended, we had to delay publication by two months to allow us time to obtain and analyze additional data from Health Care Services and to revise the report's text and graphics accordingly. In November 2015, our office began analyzing data originally provided by Health Care Services in response to our request for all Medi-Cal data related to the provision of psychotropic medications and related psychosocial services to foster children. These data provided the basis for the audit report we intended to publish in June 2016. However, about one week before we were to originally publish our audit report, Health Care Services confirmed that it had not provided all the medical services data that we originally requested. Although it had provided us data for medications, treatment authorizations, and services provided by specialty mental health plans, it had not given us services data for managed care plans or fee-for-service providers.[1] Our review showed that the additional June 22, 2016, data consisted of approximately 617 million medical service records. The related text and graphics in our audit report reflect a consolidation of the original more than 46 million medical service records provided by Health Care Services in November 2015 and the additional 617 million medical service records it subsequently provided on June 22, 2016, for a total of more than 663 million claims for medical services. Because the results from the consolidated data did not substantively affect the conclusions we reached originally or the recommendations we made, we did not ask the auditees to resubmit their written responses to our June 2016 draft report.

Recommendations

Legislature

The Legislature should require Social Services to collaborate with its county partners and other relevant stakeholders to develop and implement a reasonable oversight structure that addresses, at a minimum, the insufficiencies in oversight and monitoring of psychotropic medications prescribed to foster children highlighted in this report.

California Department of Social Services

To improve the oversight of psychotropic medications prescribed to foster children, Social Services should collaborate with counties and other relevant stakeholders to develop and implement a

[1] Please see Figure 2 on page 11 for a depiction of the types of Medi-Cal providers.

reasonable oversight structure that addresses, at a minimum, the monitoring and oversight weaknesses highlighted in this report and that ensures the accuracy and completeness of Social Services' data system and the resulting Health and Education Passports.

Counties

To better ensure that foster children only receive psychotropic medications that are appropriate and medically necessary, counties should take the following actions:

- Implement procedures to more closely monitor requests for authorizations for psychotropic medications for foster children that exceed the state guidelines for multiple prescriptions or excessive dosages. When prescribers request authorizations for prescriptions that exceed the state guidelines, counties should ensure the new court authorization forms contain all required information and, when necessary, follow up with the prescribers about the medical necessity of the prescriptions. Counties should also document their follow-up in the foster children's case files. In instances in which counties do not believe that prescribers have adequate justification for exceeding the state guidelines, counties should relay their concerns and related recommendations to the courts or the children's parents.

- Ensure that all foster children are scheduled to receive a follow-up appointment within 30 days of starting a new psychotropic medication.

- Implement a process to ensure that foster children receive any needed mental health, psychosocial, behavioral health, or substance abuse services before and concurrently with receiving psychotropic medications.

- Implement a systemic process for ensuring that court authorizations or parental consents are obtained and documented before foster children receive psychotropic medications.

Agency Comments

The state entities and the counties agreed with our recommendations.

Further, Madera County told us that because it agreed with our report's recommendations, it did not intend to submit a written response. We look forward to assessing Madera County's implementation of our recommendations when it provides updates to us at 60 days, 6 months, and one year following the issuance of our report.

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Introduction

Background

In the last decade, both public and private entities have expressed concerns about the higher prescription rates for psychotropic medications for children in foster care (foster children) than for nonfoster children.[2] In the context of foster care, state law defines psychotropic medications as those medications administered for the purpose of affecting the central nervous system to treat psychiatric disorders or illnesses. Such illnesses may include anxiety disorders, attention-deficit/hyperactivity disorder, bipolar disorder, post-traumatic stress disorder, as well as others. As the text box shows, psychotropic medications can fall into several categories, depending on the types of afflictions they treat.[3] Although some circumstances warrant the use of psychotropic medications, these medications can have serious side effects, including weight gain or loss, depression, movement disorders, pain, and sleep disturbance. Also, journal articles have linked antipsychotics to the increased risk of sudden cardiac death.

Classifications of Psychotropic Medications

- Antianxiety medications
- Antidepressants
- Antipsychotics
- Mood stabilizers
- Stimulants

Sources: California State Auditor's review of websites for organizations such as the National Institute of Mental Health, the National Alliance on Mental Illness, and the Stanford University School of Medicine.

Studies have shown that foster children are prescribed psychotropic medications more frequently than nonfoster children, raising questions about whether foster children are receiving these medications appropriately. For example, in a 2010 multistate study on psychotropic medication oversight in foster care, the Tufts Clinical and Translational Science Institute cited research showing that the use of psychotropic medication in the general child population was only 4 percent while the use of psychotropic medication for foster children ranged from 13 percent to 52 percent. Additionally, a 2011 Government Accountability Office report found that 21 percent to 39 percent of foster children received prescriptions for psychotropic medications in 2008, compared with only 5 percent to 10 percent of nonfoster children. According to the American Psychological Association, studies since the 1970s have found that children in foster care often have greater need for mental health treatment than children in the general population. However, given the potential risks associated with psychotropic medications, the higher rates at which they are prescribed to foster children is a cause for concern.

[2] Throughout this report, we use the term *foster children* to refer to children ages zero to 17 in the foster care system.

[3] Examples of psychotropic medications include the following brand names: Abilify, Ativan, Cymbalta, Haldol, Prozac, Ritalin, Seroquel, Wellbutrin, Xanax, and Zoloft.

The Prescription of Psychotropic Medications to Children in California's Foster Care System

Questions regarding the prescription of psychotropic medications to foster children are of particular importance to California, which has the largest population of foster children in the country. To determine how many of the State's more than 79,000 foster children were prescribed psychotropic medications, we used statewide data (state data) from the California Department of Social Services (Social Services) and the Department of Health Care Services (Health Care Services), two key state agencies that work with foster children. As we discuss in Chapter 2, we have concerns about the accuracy and comprehensiveness of the state data; nonetheless, they represent the best information available regarding the number of foster children statewide who were prescribed these medications. As shown in Figure 1, the state data show that nearly 12 percent of California's foster children received nearly 96,000 prescriptions for psychotropic medications paid by Medi-Cal in fiscal year 2014–15, or an average of about 10 prescriptions per child per year.[4]

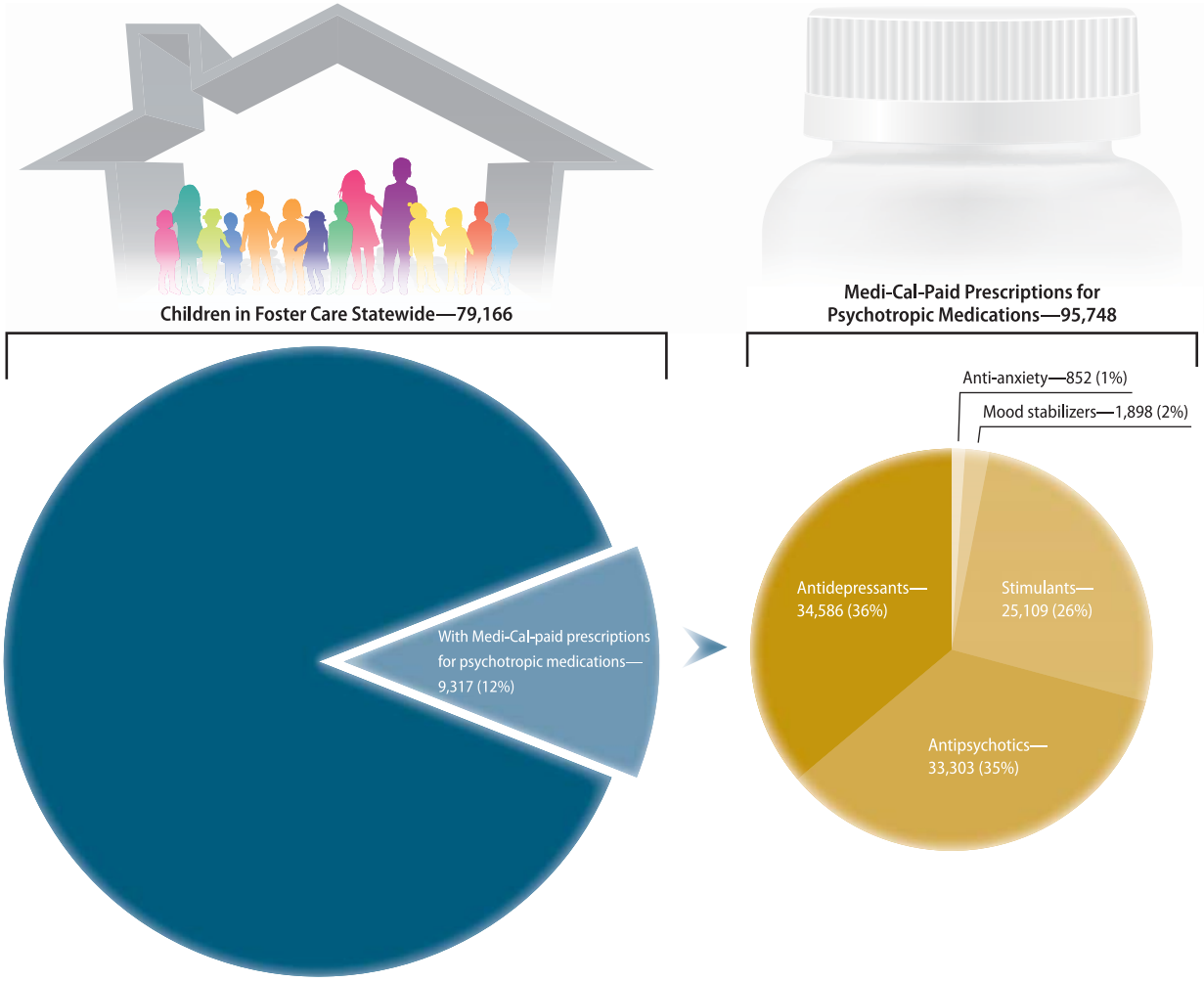
The state data show the number of foster children prescribed psychotropic medications paid through Medi-Cal decreased by more than 7 percent from fiscal year 2012–13 to fiscal year 2014–15. At the same time, the number of paid prescriptions for psychotropic medications for these children decreased by nearly 13 percent. Further, our analysis of the state data shows that older foster children were more likely to have paid prescriptions for psychotropic medications than younger ones. Nearly three quarters (74 percent) of the foster children with paid prescriptions for psychotropic medications in fiscal year 2014–15 were aged 12 to 17, compared to less than 2.5 percent aged 5 years or less.

Despite the decrease in the overall number of foster children receiving psychotropic medications, state data show that nearly half of these foster children had paid antipsychotic medication prescriptions in fiscal year 2014–15. Antipsychotics pose a particular risk for children because they have a high risk of severe side effects. Nevertheless, the state data show that antipsychotics made up nearly 35 percent of all paid prescriptions for psychotropic medications for foster children, as Figure 1 shows.

We provide summary data about foster children prescribed psychotropic medications in the Appendix beginning on page 79.

[4] The average number of paid prescriptions per foster child may reflect that some foster children received more than one type of psychotropic medication. Alternatively, it may indicate that some foster children had paid prescriptions of a single medication filled a number of times during the year (perhaps on a monthly or bimonthly basis).

Figure 1
Statewide Number and Proportion of Children in Foster Care With Prescriptions for Psychotropic Medications Paid for by Medi-Cal During Fiscal Year 2014–15



Sources: California State Auditor's analysis of data obtained from the California Department of Social Services' Child Welfare Services/Case Management System and matched Medi-Cal pharmacy data.

Foster Children and Health Care

Foster care is a social welfare program funded and administered by federal, state, and county governments. Children enter foster care through one of two channels: the child welfare system or the probation system. Within the child welfare system, state law authorizes a juvenile court to declare a child to be a dependent of the court for certain specified reasons that generally involve the parents' or caregivers' unwillingness or inability to provide adequate care, including protecting children from physical or sexual abuse. Within the probation system, state law authorizes the juvenile court

to declare a child to be a ward of the court because the child is beyond the control of his or her parent, guardian, or custodian; fails to comply with curfews or attend school; or has committed a crime. State data show that from fiscal years 2012–13 through 2014–15 about 80 percent of California's foster children with paid prescriptions for psychotropic medications were in the child welfare system, compared to about 20 percent in the probation system.

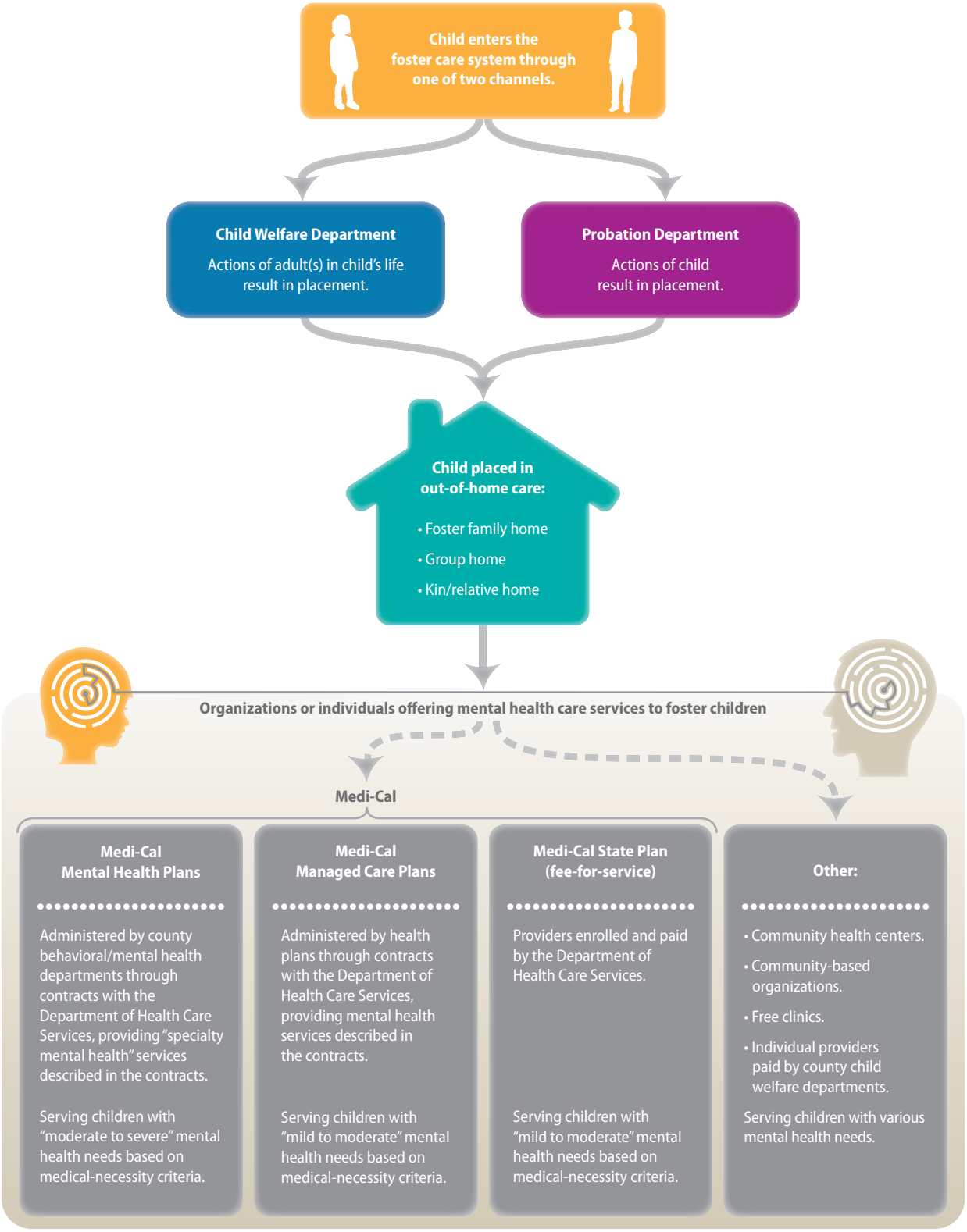
The federal Social Security Act requires that, in order to be eligible for federal payment, a state must have a plan for child welfare services that provides foster children with health care, including mental health care services. In addition, Medicaid requires—and helps pay for—the provision of necessary health services, including psychosocial services, to children covered by Medicaid, which includes foster children up to age 21. In response to these requirements, the State provides basic health care to foster children that includes health screenings within 30 days of the children entering foster care; periodic screenings and mental health assessments thereafter; and services, treatments, and medications, as needed.

Medicaid funding covers part of the health care costs of foster children, including those related to mental health care services. Its reimbursement levels vary depending upon the type of cost. For example, Medicaid will reimburse 50 percent for the costs of health care services provided to foster children. It will also reimburse 75 percent of the costs for skilled professional medical personnel—such as public health nurses—and their support staff who provide services to the foster care program.

The State and counties generally provide or acquire the remainder of the necessary funding for foster children's health care. State funding for psychosocial services for foster children can come from a variety of sources, including state public safety realignment funding from sales taxes, vehicle taxes, and fees. In addition, the Mental Health Services Act imposes a 1 percent tax on income in excess of $1 million to expand mental health services. Counties also provide their own funding and may acquire additional funding through grants.

Counties are responsible for ensuring the provision of health care services to foster children. Specifically, state law enacted in 2012 moved programmatic responsibility for child welfare services, including the support and care of foster children, from the State to the counties (child welfare services realignment). However, Social Services—which under state law is jointly responsible with the counties for establishing and supporting the child welfare services system—is still responsible for providing oversight and technical assistance to the counties. Under child welfare services realignment, the counties provide psychosocial services through different types of health care systems, as shown in Figure 2.

Figure 2
A Child in Foster Care's Path to Mental Health Services in California



Sources: California laws, state and county agency documents, and the California State Auditor's review of other information.

Oversight of the Provision of Psychotropic Medications to Foster Children

Different levels and branches of government are responsible for overseeing the provision of psychotropic medications to foster children in California. As shown in Table 1, executive branch entities at the federal, state, and county levels oversee foster children who receive psychotropic medications. Further, the judicial branch at the state and county levels also has an oversight role for these foster children.

The federal government provides oversight of the prescription of psychotropic medications through the U.S. Department of Health and Human Services (Health and Human Services). Before 2011, Health and Human Services provided general guidance to states regarding psychotropic medications and Medicaid beneficiaries but did not require the states to take any specific actions. However, in response to a change in federal law in September 2011, Health and Human Services established certain requirements with which states must now comply. For example, states must now include an outline of their protocols for ensuring the appropriate use and monitoring of psychotropic medications in their Child and Family Services Plans, which set forth the states' strategic plans for strengthening their overall child welfare systems. Health and Human Services requires states to submit these plans every five years and to submit annual progress and services reports related to their plans in the interim. Health and Human Services then uses information from the Child and Family Services Plans as well as the states' annual reports as part of the statewide assessment component of the federal child and family services review (federal review), which assesses each state's child welfare system.

Since Health and Human Services' implementation of the federal review in 1997, it has twice reviewed all the states and is currently reviewing them for the third time. Although California's past federal reviews have included little discussion of foster children who received psychotropic medications, its third review is likely to more directly address this issue. Specifically, California's most recent federal review, for which Health and Human Services published a report in 2008, included just two references to psychotropic medications: it acknowledged that stakeholders had expressed concerns that foster children had been prescribed psychotropic medications rather than being given adequate psychosocial services, and it mentioned the role of public health nurses in monitoring psychotropic medications. However, California's upcoming 2016 federal review will include information from its 2015–2019 Child and Family Services Plan, which describes California's protocols for the appropriate use and monitoring of psychotropic medications. In particular, the protocols address five key components specified by Health and Human Services' guidance: screening, assessment, and treatment plans; informed and shared decision making; medication monitoring; mental health expertise and consultation; and mechanisms for sharing accurate and up-to-date information.

We discuss the State's and counties' oversight mechanisms in more detail in Chapter 2 of our report.

Table 1
Key Entities and Mechanisms for the Oversight of Psychotropic Medications Prescribed to Children in Foster Care

PUBLIC ENTITY	OVERSIGHT ROLE FOR FOSTER CHILDREN PRESCRIBED PSYCHOTROPIC MEDICATIONS
FEDERAL	
Executive Branch	
U.S. Department of Health and Human Services—Administration for Children and Families & Centers for Medicare and Medicaid Services	Provides guidance and instructions to states regarding foster children and psychotropic medications.
STATE	
Judicial Branch	
Judicial Council	Provides guidance and instruction—through court rules, template forms, trainings, and some technical support—to county superior courts related to approving psychotropic medications for foster children.
Executive Branch	
California Department of Social Services (Social Services)	Oversees and administers programs serving California's most vulnerable residents.
Child and Family Services Division	Provides assistance in adoptions, foster care, children's programs, and child welfare services. In collaboration with the Department of Health Care Services (Health Care Services), Social Services maintains the Health Care Program for Children in Foster Care, a public health nursing program administered by local public health departments to provide public health nursing expertise to ensure the health care needs of children in out-of-home placement or foster care.
Community Care Licensing Division	Administers the Children's Residential Licensing Program, which issues licenses to homes and facilities that house foster children.
Health Care Services	Administers the Medi-Cal program, which includes specialty mental health, managed care, and fee-for-service programs.
Clinical Assurance and Administrative Support Division	Reviews and adjudicates treatment authorization requests for medications under the Medi-Cal fee-for-service program.
Mental Health Services Division	Administers, oversees, and monitors community mental health program service delivery and compliance for the Medi-Cal Specialty Mental Health Services program and the Mental Health Services Act.
Managed Care Quality and Monitoring Division	Monitors and oversees California's Medi-Cal managed care health plans and Medi-Cal managed care policy development.
Pharmacy Benefits Division	Administers Health Care Services' Medi-Cal fee-for-service drug program and responsible for the management of the Medi-Cal managed care pharmacy program.
Provider Enrollment Division	Reviews applications for providers seeking to participate directly or indirectly in the fee-for-service Medi-Cal program.
Medical Board of California	Licenses and oversees medical doctors, with the authority to investigate and discipline any physicians alleged to have committed acts of wrongdoing. It is currently in the process of acquiring Medi-Cal pharmacy claims data related to foster children and psychotropic medications to review and identify physicians who may have inappropriately prescribed psychotropic medications to foster children.
LOCAL—ALL COUNTIES	
Judicial Branch	
Superior Court	Administers the court authorization review process, which adjudicates requests to administer psychotropic medications to foster children.
Executive Branch	
Child Welfare Department/Divisions	Oversees dependents of the court and administers the counties' foster care programs.
Probation Department	Oversees wards of the court, including those who are placed into foster care.
Mental Health/Behavioral Health Department/Divisions	Administers county Medi-Cal mental health plans that provide mental health services, including case management, psychosocial therapies, and psychiatric medication support to Medi-Cal beneficiaries, including foster children and wards of the court.

Sources: California State Auditor's review of federal and state laws and various agency documents.

Guidelines for the Safe and Appropriate Use of Psychotropic Medications in the Treatment of Foster Children

A number of different entities have developed or established guidelines that can help to ensure the appropriate use of psychotropic medications in the treatment of foster children. For example, in 2009 the American Academy of Child and Adolescent Psychiatry (Academy) developed a document titled *Practice Parameter on the Use of Psychotropic Medication in Children and Adolescents*. The purpose of the document was to promote the appropriate and safe use of psychotropic medications in children and adolescents with psychiatric disorders by emphasizing best practice principles that underlie medication prescribing. Further, in 2012 the Academy developed another document titled *A Guide for Community Child Serving Agencies on Psychotropic Medications for Children and Adolescents*. The purpose of this document was to provide entities that serve children, including child welfare and juvenile justice agencies, with information regarding the role of psychotropic medications in treatment plans for children. Throughout our report, we refer to these two documents collectively as *academy guidelines*. We summarize the academy guidelines in the text box and discuss them in more detail in applicable sections of our report.

Select Recommendations from the American Academy of Child and Adolescent Psychiatry

- Health providers should follow up within at least a month of a child starting a psychotropic medication.
- Generally, a child should receive nonpharmaceutical psychosocial services before starting a psychotropic medication, and should receive such services when receiving a psychotropic medication.

Sources: California State Auditor's review of the American Academy of Child and Adolescent Psychiatry's 2009 *Practice Parameter on the Use of Psychotropic Medication in Children and Adolescents*, and its 2012 *A Guide for Community Child Serving Agencies on Psychotropic Medications for Children and Adolescents*.

The State also recently developed its own guidelines for the safe administration of psychotropic medications to foster children. In 2012, Social Services and Health Care Services initiated a statewide quality improvement project to improve techniques for monitoring psychotropic medication use among children in foster care. This project included the creation of a clinical workgroup to develop statewide guidelines for the ongoing oversight and coordination of health care services for children in foster care, including protocols and strategies to improve the appropriate use and monitoring of psychotropic medication for these children.

In March 2015, as part of this quality improvement project, Social Services and Health Care Services jointly released a document titled *California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care* (state guidelines), which they consider to be a summary of the best practices for the treatment of children who are placed in foster care. The state guidelines represent the first comprehensive effort at the state level to address the use of psychotropic medication by children in out-of-home care who are being served by the child welfare and/or probation system.

In developing these guidelines, Social Services and Health Care Services reviewed the Academy's publications, the American Academy of Pediatrics' policies, California county child welfare and behavioral health policies and practices, and the policies of child welfare and mental health agencies in other states.

The state guidelines include prescribing standards that counties can, but are not required to, use when reviewing applications to courts for authorization to prescribe psychotropic medications to foster children. According to Social Services and Health Care Services, these prescribing standards represent the current best practices and incorporate evidence-based support. The departments do not intend these prescribing standards to stifle independent treatment or care by providers but rather to form a foundation for review, with the goal to ensure that children receive the minimum number of psychotropic medications necessary in the lowest therapeutic doses that are appropriate for their ages.

As shown in the text box, these prescribing standards recommend limiting the number of concurrent psychotropic medications by class that foster children should take. They also recommend limiting psychotropic medications by dosage and by a child's age. According to the prescribing standards, counties should identify prescriptions that exceed these limitations and ask prescribers to submit additional information to justify or explain the prescriptions.

Key Standards Within the State's Guidelines for Prescribing Psychotropic Medications to Foster Children

- A foster child should generally not take multiple psychotropic medications within the same class concurrently.
- A foster child should generally be limited to taking a total number of psychotropic medications, regardless of class, that is appropriate for his or her age:

FOR CHILDREN AGED:	NO MORE THAN:
0–5 years	one psychotropic medication
6–11 years	two psychotropic medications
12–17 years	three psychotropic medications

- A foster child should generally only take psychotropic medications within recommended dosage parameters, as outlined in the Los Angeles County Department of Mental Health's *Parameters 3.8: For Use of Psychotropic Medication in Children and Adolescents.*

Source: California State Auditor's review of the *California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care.*

Scope and Methodology

The Joint Legislative Audit Committee (audit committee) directed the California State Auditor to examine state and county agencies' monitoring and oversight of foster children who have been prescribed psychotropic medications. It also directed us to review the availability and adequacy of other supportive services for foster children, such as mental health and substance abuse counseling. Table 2, beginning on the following page, lists the audit committee's objectives and the methods we used to address them.

Also, rather than publishing this audit report in June 2016 as originally intended, we had to delay publication by two months to allow us time to obtain and analyze additional data from Health Care Services and to revise the report's text and graphics accordingly. In November 2015, our office began analyzing data originally

provided by Health Care Services in response to our request for all Medi-Cal data related to the provision of psychotropic medications and related psychosocial services to foster children. These data provided the basis for the audit report we intended to publish in June 2016. However, about one week before we were to originally publish our audit report, Health Care Services confirmed that it had not provided all medical services data that we originally requested. Although it had provided us data for medications, treatment authorizations, and services provided by specialty mental health plans, it had not given us services data for managed care plans or fee-for-service providers.[5] Our review showed that the additional June 22, 2016, data consisted of approximately 617 million medical service records. The related text and graphics in our audit report reflect a consolidation of the original more than 46 million medical service records provided by Health Care Services in November 2015 and the additional 617 million medical service records it subsequently provided on June 22, 2016, for a total of more than 663 million claims for medical services. Because the results from the consolidated data did not substantively affect the conclusions we reached originally or the recommendations we made, we did not ask the auditees to resubmit their written responses to our June 2016 draft report.

Table 2
Audit Objectives and the Methods Used to Address Them

	AUDIT OBJECTIVE	METHOD
1	Review and evaluate the laws, rules, and regulations significant to the audit objectives.	• We reviewed relevant laws, rules, regulations, and guidelines related to children in foster care (foster children) and psychotropic medications. • We interviewed key staff at state and county agencies that oversee the administration and approval of psychotropic medications prescribed to foster children.
2	Identify the respective roles in overseeing the mental health care of foster children of the California Department of Social Services (Social Services), the Department of Health Care Services (Health Care Services), county child welfare service agencies and probation agencies, as well as the county mental or behavioral health departments that oversee the specialty mental health services that foster children receive. Specifically identify which agencies are responsible for ensuring that foster children eligible for Medi-Cal are receiving the mental and behavioral health services to which they are entitled under federal and state laws.	• We interviewed staff and reviewed relevant documents to identify the responsible state entities and the processes they use to oversee psychotropic medications prescribed to foster children. • For each of the four counties we visited (Los Angeles, Madera, Riverside, and Sonoma), we interviewed staff and reviewed relevant documents to identify the county agencies involved and the processes they use to oversee psychotropic medications prescribed to foster children.

[5] Please see Figure 2 on page 11 for a depiction of the types of Medi-Cal providers.

	AUDIT OBJECTIVE	METHOD
3	Examine the adequacy and accuracy of data tracked by these agencies on whether foster children who are being prescribed psychotropic medications also receive other appropriate nonpharmacological supportive services, such as counseling. In particular, evaluate whether these data are sufficient to determine the extent to which foster children are receiving mental health, psychosocial, behavioral health, and substance abuse services. a. Evaluate how the above data are tracked and used, how their accuracy is ensured, and whether opportunities exist to better gather and use this information. To the extent that barriers exist to effective data collection and use, identify potential solutions. b. For a selection of foster children at the four counties visited, determine how well the entities listed in Objective 2 have carried out their applicable responsibilities. Using these results, if applicable, identify ways in which oversight of these practices could be improved.	• For our review, we selected 20 foster children overseen by the child welfare services and probation agencies at each of the four counties we visited, for a total of 80 children. For each of these 80 children, we examined the following: - Hard-copy case files and electronic records, if available, at the counties. - Electronic case file information from Social Services' Child Welfare Services/ Case Management System (Social Services' data system). - Electronic claims information from Health Care Services for psychosocial services, psychotropic medications, follow-up visits, and treatment authorization requests. • To assess the adequacy and accuracy of the data tracked by Social Services' data system, we compared information from all three of these sources. We summarize the results of our review in Table 3 and provide more detailed information in Chapters 1 and 2, including Table 15 on page 57, of our audit report. • For the purposes of our audit, we limited our review to foster children aged zero through 17. • Using relevant criteria and oversight processes identified in Objectives 1 and 2, we reviewed available documents for the 80 selected foster children to identify information related to their filled prescriptions for psychotropic medications, their court authorizations or parental consents for psychotropic medications, the psychosocial services they were provided, and the follow-up visits they received. • We reviewed the Health and Education Passports for the 80 selected foster children and determined the accuracy and completeness of the information within them. • Using Health Care Services' data for Medi-Cal claims and treatment authorization requests and documentation from the case files, we determined whether Health Care Services received and reviewed treatment authorization requests according to its regulations and policies related to psychotropic medications. • We reviewed data reports identifying potential discrepancies regarding court authorizations and the prescription of psychotropic medications for foster children in the four counties we visited to assess how the State and counties help assure accuracy of the information within Social Services' data system. • We calculated the number of foster children without a Medi-Cal claim for at least one follow-up medication service within 30 days after filling a new psychotropic medication prescription. To do so, we adapted the National Committee for Quality Assurance's methodology for follow-up care for children with newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication. Specifically, at the recommendation of Health Care Services, we applied this methodology to foster children of all ages who had any new psychotropic medication—not just for children aged six to twelve with a new ADHD medication—and counted follow-up medication services if the prescriber recorded a mental health diagnosis in the Medi-Cal service data.
4	Determine whether any structural deficiencies, network inadequacies, or adverse incentives exist within the county child welfare services, behavioral health, or Medi-Cal systems that may be leading to the overuse of psychotropic medications among foster children. Specifically, evaluate whether viable alternatives to these medications are being underutilized because of funding deficiencies, disincentives, or other identifiable reasons.	Using results from our case file review described under Objective 3, we identified deficiencies in the oversight process. To identify the causes for these deficiencies, we examined relevant documents and interviewed state and county staff.

continued on next page . . .

	AUDIT OBJECTIVE	METHOD
5	Examine the existing level of oversight of doctors prescribing psychotropic medications to foster children, evaluate whether this oversight is sufficient to identify and remedy noncompliance with accepted standards of practice, and if appropriate, identify opportunities to strengthen this oversight.	To determine the extent of their involvement in the oversight of prescribing physicians, we interviewed staff at the Medical Board of California and staff in ombudsman offices within Social Services and Health Care Services and examined relevant documents.
6	Evaluate existing processes used by the courts, the county child welfare services system, and mental health plans and providers to ensure that ongoing use of psychotropic medication by foster children is monitored for negative reactions, side effects, or overdoses.	We included the work associated with this objective—examining physician follow up—as part of Objective 3.
7	Identify whether county child welfare services agencies are ensuring that necessary health documentation is being transmitted to caregivers, prescribers, and other stakeholders when foster children receiving psychotropic medication change placement.	We included the work associated with this objective—examining Health and Education Passports—as part of Objective 3.
8	Determine whether any other states have implemented innovations or oversight systems that have successfully reduced the use of psychotropic medications in foster children or improved their access to nonpharmacological supports, and evaluate whether California could benefit from some of these policies or practices.	• We identified and reviewed documents, including bulletins issued by the U.S. Department of Health and Human Services, reports, studies, and journal/media articles regarding practices states have in place for the oversight of psychotropic medications. • We maintained awareness for potential best practices during our review of county oversight processes as part of Objectives 2 and 3. • Other than certain county practices we describe in Chapter 1, we identified no innovations or oversight practices used by other entities that we would recommend for use in California.
9	Review and assess any other issues that are significant to the audit.	We did not identify any other significant issues.

Sources: California State Auditor's analysis of state law, federal law, planning documents, and information and documentation identified in the table column titled *Method*.

Assessment of Data Reliability

In performing this audit, we obtained electronic data files extracted from the information systems listed in Table 3. The U.S. Government Accountability Office, whose standards we are statutorily required to follow, requires us to assess the sufficiency and appropriateness of computer-processed information that we use to support findings, conclusions, or recommendations. Table 3 describes the analyses we conducted using data from these information systems, our methods for testing, and the results of our assessments. Although these determinations may affect the precision of the numbers we present, there is sufficient evidence in total to support our audit findings, conclusions, and recommendations.

Table 3
Methods Used to Assess Data Reliability

INFORMATION SYSTEM	PURPOSE	METHOD AND RESULT	CONCLUSION
Department of Health Care Services (Health Care Services) Paid Claims and Encounters System (PCES), as of November 2015	To identify psychosocial and medication services through Medi-Cal for children in foster care (foster children) who had paid psychotropic medication prescriptions filled during fiscal year 2013–14.	We performed data-set verification procedures and electronic testing of key data elements and did not identify significant issues. We did not perform accuracy or completeness testing on these data because the source documentation is located at various locations throughout the State, making such testing cost-prohibitive.	Undetermined reliability for these audit purposes. Although this determination may affect the precision of the numbers we present, there is sufficient evidence in total to support our audit findings, conclusions, and recommendations.
Health Care Services California Medicaid Management Information System (CA-MMIS), as of November 2015	To identify foster children who had multiple psychotropic medication prescriptions filled in the same medication class, or who had more psychotropic medication prescriptions filled than recommended by the State's guidelines during fiscal year 2014–15.	In our review of the more than 663 million claims for Medi Cal services, we found that more than 2.7 million of these claims—or less than half a percent—did not have sufficient identifying information for us to determine if the claim was for a child in foster care. We determined that none of these more than 2.7 million claims were for psychosocial services for children and only 6,155 were for follow-up medication services provided to children between July 1, 2013, and July 31, 2014. Because these claims did not have sufficient identifying information, such as a social security number, we were not able to determine whether the claim was for a child in foster care. Therefore, we excluded them from our analyses.	
Health Care Services Service Utilization Review, Guidance, and Evaluation (SURGE) system, as of March 2016	To identify whether a selection of 80 foster children's psychotropic medication prescriptions had approved Treatment Authorization Requests from July 2013 through December 2015.	We performed data-set verification procedures and electronic testing of key data elements and did not identify significant issues. We did not perform accuracy and completeness testing on these data because the SURGE system is a mostly paperless system. Alternatively, we could have reviewed the adequacy of selected application controls, but we determined that this level of review was cost-prohibitive.	
California Department of Social Services (Social Services) Child Welfare Services/ Case Management System (CWS/CMS), as of November 2015, and matched Medi-Cal pharmacy data, as of December 2015	• To identify foster children in the State and in each county for each fiscal year from 2012–13 through 2014–15. • To calculate various statistics related to foster children who had psychotropic medication prescriptions filled during fiscal years 2012–13 through 2014–15. • To identify foster children who had psychotropic medication prescriptions filled during fiscal year 2014–15 and who had court authorizations or parental consents to receive medication recorded in CWS/CMS. • To choose a selection of cases for foster children who had psychotropic medication prescriptions filled from April 2014 through March 2015.	We performed data-set verification procedures and electronic testing of key data elements and did not identify significant issues. We reviewed existing information to determine what is already known about the data and found that prior audit results indicate there are pervasive weaknesses in Social Services' general controls over its information systems. Further, as discussed in Chapter 2, we observed inaccurate and incomplete medical information in CWS/CMS.	Not sufficiently reliable. Although this determination may affect the precision of the numbers we present, there is sufficient evidence in total to support our audit findings, conclusions, and recommendations.

Sources: California State Auditor's analysis of various documents, interviews, and data from Health Care Services and Social Services.

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Chapter 1

THE COUNTIES HAVE NOT ALWAYS PROVIDED ADEQUATE OVERSIGHT TO ENSURE THE APPROPRIATENESS OF THE PSYCHOTROPIC MEDICATIONS THAT CHILDREN IN FOSTER CARE RECEIVE

Chapter Summary

In 2015, the California Department of Social Services (Social Services) and the Department of Health Care Services (Health Care Services) adopted guidelines (state guidelines) for the safe administration of psychotropic medications to children in foster care (foster children). Although the state guidelines are a valuable tool that counties should use to ensure that foster children do not receive inappropriate or unnecessary psychotropic medications, some counties have yet to adopt them. Consequently, when we reviewed the case files for 80 foster children at the four counties we visited—Los Angeles, Madera, Riverside, and Sonoma—we found that many foster children had been authorized to receive psychotropic medications in quantities and dosages that exceeded the state guidelines. Although exceeding the state guidelines may be medically appropriate in some circumstances, we found no evidence that the counties had followed up with the health care providers in these cases. When counties do not follow up regarding prescriptions that exceed state guidelines, they cannot ensure that they are reducing foster children's exposure to potentially inappropriate medication interventions.

Further, the counties have not always ensured that they followed best practices relating to the health services that foster children should receive in addition to their psychotropic medications. Guidelines from the American Academy of Child and Adolescent Psychiatry (academy guidelines) state that follow-up visits and corresponding psychosocial services are important aspects of mental health treatment. However, the State's data show that in fiscal year 2013–14, more than 29 percent of the State's foster children who had a filled prescription for a new psychotropic medication did not have a corresponding Medi-Cal claim for a follow-up medication service within 30 days after the prescription was filled, thus increasing the risk that any harmful side effects would go unaddressed. In addition, a significant number of foster children do not appear to have received psychosocial services around the time of their prescriptions for new psychotropic medications; therefore, the children may not have received the services needed to treat their conditions.

Finally, we found that a significant number of foster children had at least one paid prescription for psychotropic medications without required court approval or parental consent, which is a violation of state law. Specifically, 28 of the 80 foster children in our case file review had at least one prescription for psychotropic medications without court or parental authorization. Further, when we looked at the state data, we found 65 percent of the foster children statewide with paid prescriptions for psychotropic medications were prescribed at least one psychotropic medication without the appropriate authorization recorded.

By Failing to Adopt the State Guidelines, Some Counties May Be Missing an Opportunity to Better Protect Foster Children From the Risks of Inappropriate or Unnecessary Psychotropic Medications

As we discuss in the Introduction, Social Services and Health Care Services developed recommended state guidelines in 2015 for the safe administration of psychotropic medications to foster children. By following these guidelines when reviewing health care providers' requests to prescribe psychotropic medications, counties can better ensure the appropriateness and necessity of the psychotropic medications foster children receive. However, we found that some counties have yet to adopt the state guidelines and thus may be missing an opportunity to better protect the foster children under their care.

According to state law, a foster child cannot receive psychotropic medications without the authorization of either a juvenile court or the child's parents.

In developing the state guidelines, Social Services and Health Care Services intended to create a tool that prescribers, pharmacists, and courts could use when reviewing foster children's prescriptions for psychotropic medications. According to state law, a foster child cannot receive psychotropic medications without the authorization of either a juvenile court or the child's parents, depending upon whether the court has delegated the ability to make such decisions to the child's parents. To receive court authorization, a health care provider must fill out an application requesting approval to prescribe the medication. The county then reviews these applications and should determine whether the prescription complies with the state guidelines. To the extent that a prescription exceeds the guidelines, the county should follow up with the provider to inquire about the prescription's medical necessity, if the prescriber did not thoroughly explain this in the application. If the county does not believe a provider has adequate justification for exceeding the state guidelines, the county should recommend to the court that it not authorize the prescription.

However, only two of the four counties that we reviewed have adopted either the 2015 state guidelines or very similar guidelines. For example, Los Angeles County adopted guidelines that are very similar to the state guidelines. Like the state guidelines, Los Angeles County's guidelines generally only allow foster children to be concurrently

prescribed one psychotropic medication per class.[6] Furthermore, the State adopted Los Angeles County's dosage parameters as part of its guidelines. The only significant difference between the two sets of guidelines is that Los Angeles' guidelines allow three psychotropic medications for children nine years and older rather than for children who are 12 and older, as the state guidelines recommend. According to the medical director of Los Angeles County's Juvenile Court Mental Health Services (LA Juvenile Court Services), Los Angeles' guidelines for children aged 9 to 11 differ from the state guidelines because anxiety disorders often manifest in children around the age of nine.

Los Angeles' guidelines allow three psychotropic medications for children nine years and older rather than for children who are 12 and older, as the state guidelines recommend.

In part to ensure that health care providers comply with its guidelines, Los Angeles County established the LA Juvenile Court Services, a unit within its Department of Mental Health. LA Juvenile Court Services assists the juvenile court in making decisions to approve or deny prescribers' requests to initiate or continue psychotropic medications for foster children. LA Juvenile Court Services' staff includes a child psychiatrist and a pharmacist, both of whom review each request to ensure its adherence to the county's guidelines. If a request for medication is outside these parameters, the LA Juvenile Court Services reviewers will generally follow up with the prescriber to determine if the prescription in question is medically necessary. If the reviewers determine that the request is not safe and appropriate, they will recommend that the court either deny the request or approve it for only 45 days, with the expectation that the child's medication regimen will be changed after that time.

Similarly, Madera County relies upon the state guidelines when reviewing prescriptions for psychotropic medications for foster children. For example, the policies of Madera County's Child Welfare Services Division (Madera Child Services) require the county's public health nurse to review all requests for court authorizations to identify proposed psychotropic medications that are outside Los Angeles County's dosage parameters (which are also the parameters the State adopted). In addition, the public health nurse also determines whether prescribers are seeking court approval to prescribe multiple psychotropic medications within the same class or more psychotropic medications than foster children should take based on their age according to the state guidelines. The public health nurse documents her review of these and other risk factors on a psychotropic medication monitoring review form. If the public health nurse has concerns about the proposed medications based on the risk factors she has identified, the nurse and the child's assigned social worker will contact the health care provider. If county staff are unable to resolve their concerns with the provider, they will document their opposition to the prescription authorization request with the court.

[6] We describe the classifications for psychotropic medications in the Introduction.

In contrast, Sonoma County uses its own standards, which are less specific than the state guidelines, when reviewing requests for psychotropic medications. Specifically, in May 2015 the Sonoma County Department of Health Services, Behavioral Health Division (Behavioral Health Division) entered into an intracounty memorandum of understanding with the Sonoma County Department of Human Services, Family, Youth and Children's Division (Children's Division) to provide pediatric psychiatrists to review requests for court authorization for prescriptions for psychotropic medications for foster children. However, according to the Behavioral Health Division's Medical Director, the reviewing psychiatrists are expected to ensure that proposed prescriptions adhere to a 1999 county policy rather than to the state guidelines. Although this county policy is consistent with the state guidelines in certain areas, it references another document that contains dosage restrictions based on Los Angeles County's 1997 dosage parameters rather than the State's current dosage standards. In addition, the policy does not contain any specific age-related restrictions on psychotropic medications. Behavioral Health Divisions' medical director acknowledged that Sonoma County's internal policies are outdated, and he stated that the county is in the process of updating its policies to reflect the guidelines that Social Services and Health Care Services released in 2015.

Riverside County also uses its own, less specific guidelines when reviewing foster children's psychotropic medication prescriptions. According to Riverside County's policies, a Riverside University Health System—Behavioral Health (Riverside Behavioral Health) child and adolescent psychiatrist reviews all requests for court authorization for foster children's psychotropic medications. However, according to Riverside Behavioral Health's medical director, the psychiatrist ensures that the prescriptions adhere to a 2011 county policy that differs significantly from the state guidelines. For example, Riverside's policy allows the concurrent prescriptions of two medications within the same class without requiring documentation; however, the state guidelines recommend that children receive no more than one medication within the same class without justification. Further, unlike the state guidelines, Riverside County's policy does not contain any specific age-related restrictions on psychotropic medications. Finally, Riverside County's policy contains specific maximum dosage limitations for antipsychotic medications only; it requires all other prescriptions for psychotropic medications to comply with the U.S. Food and Drug Administration's recommended maximum dosages unless the providers document their reasons for exceeding these limits.

Riverside County's policy allows the concurrent prescriptions of two medications within the same class, and the policy does not contain any specific age-related restrictions on psychotropic medications.

According to Riverside Behavioral Health's mental health services administrator, Riverside County has been working to implement the state guidelines. Riverside County's Public Health, Behavioral

Health, and Public Social Services departments have met and agreed to develop a memorandum of understanding that will adhere to the state guidelines. Riverside County's Public Social Services department has developed a draft of this memorandum, and Riverside Behavioral Health will offer an amended draft for all three county departments' consideration after our audit report is released.

When counties such as Sonoma and Riverside do not use state guidelines, they miss a valuable opportunity to improve their oversight practices. Not surprisingly, we generally found more instances in Sonoma and Riverside County of authorizations of prescriptions for foster children that exceeded the state guidelines than we did for Los Angeles and Madera counties. We believe that the state guidelines are a valuable tool that counties should leverage to improve their oversight of foster children who are prescribed psychotropic medications.

State guidelines are a valuable tool that counties should leverage to improve their oversight of foster children who are prescribed psychotropic medications.

Foster Children Throughout the State Have Been Authorized to Receive Amounts of Psychotropic Medications That Exceed the State Guidelines

As previously discussed, the state guidelines include maximum amounts and dosages of psychotropic medications that foster children should receive. Nonetheless, when we reviewed the case files for 80 foster children at the counties we visited, we found that many had been prescribed psychotropic medications in amounts and dosages that exceeded the state guidelines. Although prescriptions that exceed the state guidelines may be appropriate under some circumstances, we often found little indication that the counties had followed up with the providers in question to ensure the appropriateness of the medications. Further, our review of statewide data (state data) from Social Services and Health Care Services indicates that many foster children prescribed psychotropic medications statewide may have received these medications in excess of the state guidelines. As discussed in the Introduction as well as in Chapter 2, we have concerns about the accuracy and comprehensiveness of the state data. Nevertheless, we used them in our analysis because they are currently the best data available that speak to the number of foster children prescribed psychotropic medications statewide.

In response to a recent state law, the Judicial Council of California (Judicial Council) adopted new and revised forms—which became effective in July 2016—to be used in the court authorization process for foster children's psychotropic medications. The proper completion of these newly revised forms should provide county staff with additional information necessary to identify instances when foster children are prescribed psychotropic medications

in amounts or dosages that exceed the state guidelines. Among other things, these revised forms require prescribers to explain for each foster child why they prescribed more than one psychotropic medication in a class and dosages that are outside the state guidelines. If these forms are not properly completed, county staff will need to follow up with prescribers to obtain information necessary to ensure that the prescriptions beyond the state guidelines are appropriate.

Fourteen Percent of the Foster Children We Reviewed Were Authorized to Receive Multiple Psychotropic Medications From the Same Drug Class

The state guidelines recommend that a foster child should take no more than one psychotropic medication at a time from each medication class. Common classes of psychotropic medications include antipsychotics, antidepressants, mood stabilizers, stimulants, and antianxiety medications. The concurrent use of multiple psychotropic medications from the same class can lead to extremely harmful side effects. For example, a foster child taking multiple antidepressants could experience serotonin syndrome, which can be life-threatening and can cause symptoms including high fever, seizures, irregular heartbeat, and unconsciousness.

When we reviewed the case files for 80 foster children, we found that 11 (14 percent) were authorized to simultaneously take multiple psychotropic medications within the same drug class during our audit period.

Nevertheless, when we reviewed the case files for 80 foster children, we found that 11 (14 percent) were authorized to simultaneously take multiple psychotropic medications within the same drug class during our audit period. As shown in Table 4, five of the foster children whose cases files we reviewed were authorized by the courts or their parents to simultaneously take multiple psychotropic medications within the same class even after the State released its guidelines. All five of these cases were from Riverside and Sonoma counties, which have yet to adopt the state guidelines. Further, none of these five case files contained any documentation demonstrating that the counties followed up with providers to question the need for simultaneously prescribing multiple psychotropic medications from the same class.

The juvenile court in Riverside County authorized the prescriptions in three of these cases, while parents consented to prescriptions for Sonoma County foster children in the other two cases. In one of these cases, a teenaged foster child in Riverside County was prescribed three psychotropic medications at the same time: two antidepressants and a mood stabilizer. In another case, a teenaged foster child in Sonoma County was prescribed two antipsychotics concurrently, which studies have called out as a potentially dangerous combination that should generally be avoided.

Table 4
Cases in Which Counties Did Not Have Records That They Questioned Prescriptions That Exceeded the State's Recommended Guidelines Related to Classes of Psychotropic Medications

	AT LEAST ONE INSTANCE WHERE PRESCRIPTIONS EXCEEDED GUIDELINES FOR NUMBER OF PSYCHOTROPIC MEDICATIONS WITHIN SAME CLASS	
COUNTY	BEFORE THE STATE PUBLISHED GUIDELINES	AFTER THE STATE PUBLISHED GUIDELINES
Los Angeles	0/20 cases	0/20 cases
Madera	1/20	0/20
Riverside	2/20	3/20
Sonoma	7/20	2/20
Totals	**10/80 cases**	**5/80 cases***
	13%	**6%**

Sources: California State Auditor's analysis of records at county welfare services and behavioral health departments.

* We identified four cases in which foster children were prescribed numbers of psychotropic medications that exceeded the State's recommended guidelines both before and after the State adopted those guidelines. Therefore, a total of 11 (14 percent) of the 80 foster children whose case files we reviewed were authorized to simultaneously take multiple medications within the same drug classification during our audit period.

Four of these five children had also been authorized to take multiple medications before the State adopted its guidelines. Including these four children, we found a total of 10 foster children who were authorized to take multiple medications before the state guidelines took effect. Seven of these children lived in Sonoma County. For three of these children, we did not see any evidence that Sonoma county staff followed up with providers to verify that the concurrent medications were medically necessary before they forwarded the requests to the Superior Court of California, County of Sonoma (Sonoma County Court) for approval. For example, in one of these cases, a foster child was prescribed five different psychotropic medications at the same time, two of which were antipsychotics, yet we did not see any evidence that the county questioned the prescriber on the need to prescribe two antipsychotic medications simultaneously. In the other four instances, the Sonoma County Court delegated to the children's parent(s) the authority to approve their psychotropic medications. Since Sonoma County does not have a process for reviewing prescriptions that parents authorize, it did not follow up with the prescribers in these cases.

According to a program manager in the Children's Division, Sonoma County plans to expand its current review process—which we described previously—to include prescriptions authorized by parental consent in the future. In addition, similar to the county's current process for advising the court about the appropriateness of proposed psychotropic medications, the reviewing psychiatrist

should provide these parent(s) an opinion on the efficacy and appropriateness of proposed medications so that they are able to make a more informed decision about whether to approve these medications for their children. It is imperative that Sonoma County make this change as soon as possible because the state data for fiscal year 2014–15 indicates that more than 20 percent of Sonoma County's foster children receive parental consent to take psychotropic medications. In contrast, less than 1 percent of Los Angeles, Madera, and Riverside counties' foster children receive parental consent to take these medications. Further, a deputy director at Social Services stated that foster children should receive the same level of oversight from the county with regard to their psychotropic medications whether a court or parent authorizes the medication.

As discussed previously, LA Juvenile Court Services' staff use guidelines that are nearly identical to the state guidelines to oversee proposed psychotropic medications that require court authorization. This is the likely reason that we did not note any instances in the cases we reviewed in which Los Angeles County did not follow up with providers who prescribed foster children multiple medications in the same class. Similarly, we only noted one instance in which a court authorized a Madera County foster child to take multiple medications in the same classification without evidence that the county followed up with the provider, and this instance occurred before the State issued its guidelines, which Madera subsequently adopted.

As shown in Table 5, the state data indicate that of the 9,317 foster children with filled psychotropic medication prescriptions statewide in fiscal year 2014–15, 851 were prescribed multiple antidepressants at the same time; 330 were prescribed multiple antipsychotics at the same time; and 193 were prescribed multiple stimulants at the same time.[7] The state data show that a lower percentage of foster children in Los Angeles County who were prescribed psychotropic medications received multiple medications from the same class than the statewide average, likely reflecting the fact that this county adopted the state guidelines. Conversely, the statewide data indicate that a greater proportion of Sonoma and Riverside county's foster children who were prescribed psychotropic medications were concurrently prescribed multiple antidepressants compared to the statewide average. For example, nearly 18 percent of Sonoma County's foster children prescribed psychotropic medications received multiple antidepressants at the same time, which is nearly double the statewide average of 9 percent. Similarly, Riverside County's percentage of foster

[7] The state guidelines state that the antidepressant trazodone is *excepted* when prescribed as a hypnotic. Because the state data did not identify when trazodone was prescribed as a hypnotic, we did not exclude it.

children with filled prescriptions for more than one antidepressant at the same time was nearly 12 percent, which is also greater than the statewide average.

As discussed earlier, the Judicial Council recently adopted new and revised forms to request court authorization of psychotropic medications for foster children. These forms now require physicians to describe why they prescribed more than one psychotropic medication in a class for the child. County staff can use this information to better ensure that foster children were properly prescribed psychotropic medications.

Table 5
Number and Proportion of Children in Foster Care With Filled Prescriptions for Multiple Psychotropic Medications in the Same Class, Statewide and for Four Counties, Fiscal Year 2014–15

	TOTAL NUMBER OF FOSTER CHILDREN WITH FILLED PSYCHOTROPIC MEDICATION PRESCRIPTIONS	FOSTER CHILDREN WITH MORE THAN ONE FILLED ANTIDEPRESSANT PRESCRIPTION*		FOSTER CHILDREN WITH MORE THAN ONE FILLED ANTIPSYCHOTIC PRESCRIPTION*		FOSTER CHILDREN WITH MORE THAN ONE FILLED STIMULANT PRESCRIPTION*	
		NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Statewide	9,317	851	9.1%	330	3.5%	193	2.1%
Counties We Visited							
Los Angeles	3,194	267	8.4%	69	2.2%	42	1.3%
Madera	21	†	†	†	†	†	†
Riverside	595	71	11.9	26	4.4	†	†
Sonoma	140	25	17.9	†	†	†	†

Sources: California State Auditor's analysis of data obtained from the Department of Health Care Services' California Medicaid Management Information System, data obtained from the California Department of Social Services' Child Welfare Services/Case Management System, and matched Medi-Cal pharmacy data.

Note: The term *foster children* refers to children aged zero to 17 in the foster care system.

* For our analysis, we considered foster children to be on more than one psychotropic medication only if they had filled prescriptions for more than one psychotropic medication within the same medication classification for more than 30 consecutive days.

† To protect individual privacy, we omitted this number because it would identify 10 or fewer foster children. Such omission is in accordance with aggregate data reporting guidelines issued by the Department of Health Care Services.

Ten Percent of Foster Children We Reviewed Were Authorized to Receive More Psychotropic Medications Than State Guidelines Recommend for Children Their Ages

Our review also found that some counties did not follow up with prescribers to ensure that foster children only received psychotropic medications that were appropriate for children of their ages. As explained in the Introduction, state guidelines recommend that children five years old or younger take no more than one psychotropic medication at a time, children aged 6 to 11 take no more than two medications, and children aged 12 to 17 take no more than three medications.

However, as shown in Table 6, eight (10 percent) of the 80 foster children whose case files we reviewed had been authorized to take more psychotropic medications than the state guidelines recommended for their ages, yet the counties did not appear to have sought additional justification from the prescribers. By not questioning providers requesting psychotropic medications beyond the guidelines, counties cannot ensure that foster children are taking a number of psychotropic medications that are safe and appropriate for their age.

Table 6
Cases in Which Counties Did Not Have Records That They Questioned Prescriptions of Psychotropic Medications That Exceeded the State's Guidelines for Foster Children's Ages

	AT LEAST ONE INSTANCE WHERE PRESCRIPTIONS EXCEEDED GUIDELINES FOR TOTAL NUMBER OF PSYCHOTROPIC MEDICATIONS BY AGE	
COUNTY	BEFORE THE STATE PUBLISHED GUIDELINES	AFTER THE STATE PUBLISHED GUIDELINES
Los Angeles	2/20 cases	0/20 cases
Madera	0/20	0/20
Riverside	2/20	0/20
Sonoma	4/20	1/20
Totals	**8/80 cases**	**1/80 cases***
	10%	**1%**

Sources: California State Auditor's analysis of records at county welfare services and behavioral health departments.

* We identified one case in which a child was prescribed psychotropic medications that exceeded the State's recommended guidelines both before and after the State adopted those guidelines. Therefore, eight (10 percent) of the 80 children whose case files we reviewed were authorized to take more psychotropic medications than state guidelines recommend for their ages.

These eight cases all occurred before the issuance of the state guidelines. Four of these eight cases were Sonoma County foster children, three of whom received their parents' approval to take these medications. In fact, one of these Sonoma County foster children had parental authorization to take these medications both before and after the State issued its guidelines. After the State issued its guidelines, the parents authorized this teenaged foster child to take five psychotropic medications at the same time, although state guidelines recommend children that age should receive no more than three.

In two of the eight cases, Los Angeles County courts authorized foster children to take a number of psychotropic medications that exceeded the state guidelines for their ages. However, these two instances occurred before the State released its guidelines, and neither involved prescriptions that exceeded Los Angeles County's guidelines. In one of these cases, a young foster child was prescribed three psychotropic medications at the same

time. Although the state guidelines would later recommend that foster children aged 6 to 11 only receive up to two psychotropic medications concurrently, Los Angeles County's guidelines allow children aged 9 to 17 to receive up to three of these medications. In the second case, a teenaged Los Angeles foster child was prescribed four psychotropic medications concurrently. However, one of the four medications was Cogentin, which Los Angeles County's guidelines do not count toward the maximum number of psychotropic medications.[8]

The state data show that a significant number of children statewide also had filled psychotropic medication prescriptions that exceeded the recommendations in the state guidelines for their ages. As shown in Table 7 on the following page, the state data indicate that 29 foster children aged zero to 5 received more than one filled psychotropic medication prescription at the same time during fiscal year 2014–15. Furthermore, the state data show that 159 foster children aged 6 to 11 received more than two filled psychotropic medication prescriptions and that 90 foster children aged 12 to 17 received more than three filled psychotropic medication prescriptions at the same time.

In fiscal year 2014–15, 159 children in foster care aged 6 to 11 received more than two filled psychotropic medication prescriptions at the same time and 90 foster children aged 12 to 17 received more than three filled psychotropic medication prescriptions at the same time.

Los Angeles County's statistics, shown in Table 7 on the following page, were lower than the corresponding statewide averages while Riverside County's statistics were higher. Specifically, less than half a percent of Los Angeles County's foster children aged 12 to 17 receiving psychotropic medication prescriptions had more than three of these medications. Conversely, the rate in Riverside County for foster children the same age was 1.8 percent, or nearly double the statewide average. As discussed previously, Los Angeles County uses guidelines that include age-based restrictions on psychotropic medications that are very similar to the state guidelines, while Riverside County does not. This likely explains why Los Angeles County's statistics compare more favorably than Riverside County's statistics to the statewide average.

[8] According to the medical director of Los Angeles County's Juvenile Court Mental Health Services, the county excluded Cogentin from its standards because it is primarily used to counteract side effects of antipsychotics, not to treat symptoms of a mental or behavioral disorder. The state guidelines do not make an exception for Cogentin in determining the maximum number of medications a child may receive.

Table 7
Number and Proportion of Children in Foster Care With Filled Prescriptions for Psychotropic Medications That Exceeded the State's Recommended Guidelines for Age Groups, Statewide and for Four Counties, Fiscal Year 2014–15

	TOTAL NUMBER OF FOSTER CHILDREN WITH FILLED PSYCHOTROPIC MEDICATION PRESCRIPTIONS	FOSTER CHILDREN AGE 0–5 WITH MORE THAN ONE FILLED PSYCHOTROPIC MEDICATION PRESCRIPTION*	FOSTER CHILDREN AGE 6–11 WITH MORE THAN TWO FILLED PSYCHOTROPIC MEDICATION PRESCRIPTIONS*		FOSTER CHILDREN AGE 12–17 WITH MORE THAN THREE FILLED PSYCHOTROPIC MEDICATION PRESCRIPTIONS*	
			NUMBER	PERCENT	NUMBER	PERCENT
Statewide	9,317	29	159	1.7%	90	1.0%
Counties We Visited						
Los Angeles	3,194	†	34	1.1%	14	0.4%
Madera	21	†	†	†	†	†
Riverside	595	†	†	†	11	1.8
Sonoma	140	†	†	†	†	†

Sources: California State Auditor's analysis of data obtained from the Department of Health Care Services' California Medicaid Management Information System, data obtained from the California Department of Social Services' Child Welfare Services/Case Management System, and matched Medi-Cal pharmacy data.

Notes: State guidelines recommend that children aged zero to 5 take no more than one psychotropic medication, children aged 6 to 11 take no more than two psychotropics medications, and children aged 12 to 17 take no more than three psychotropic medications.

The term *foster children* refers to children aged zero to 17 in the foster care system.

* For our analysis, we considered foster children to be on more than one psychotropic medication only if they had filled prescriptions for more than one psychotropic medication for more than 30 consecutive days.

† To protect individual privacy, we omitted this number because it would identify 10 or fewer foster children. Such omission is in accordance with aggregate data reporting guidelines issued by the Department of Health Care Services.

Nearly a Quarter of the Foster Children We Reviewed Were Authorized to Take Larger Dosages of Psychotropic Medications Than State Guidelines Recommend

Our review of 80 case files found that many foster children were authorized to take psychotropic medications in dosages that exceeded the state guidelines without the counties' adequately documenting that they had contacted the prescribers. As described previously, when Social Services and Health Care Services created the state guidelines, they adopted Los Angeles County's dosage parameters. These dosage parameters established maximum daily dosages for commonly prescribed psychotropic medications.

However, as shown in Table 8, our review of the case files for 80 foster children identified 18 foster children (23 percent) for whom the courts or their parents approved at least one psychotropic medication with a maximum daily dosage that exceeded the state guidelines. Ten of these children were authorized to take these medications before the State issued its guidelines. One of these 10 children, along with eight more children, were all authorized to take these medications after the State released its guidelines. We found no evidence in any of these cases that the counties identified these prescriptions as potential problems and questioned the prescribers about the dosages.

Table 8
Cases in Which Counties Did Not Have Documentation That They Questioned Providers When Prescriptions Went Beyond the State's Recommended Guidelines for Dosages

	AT LEAST ONE PRESCRIPTION EXCEEDED GUIDELINES FOR MAXIMUM DAILY DOSAGE	
COUNTY	BEFORE THE STATE PUBLISHED GUIDELINES	AFTER THE STATE PUBLISHED GUIDELINES
Los Angeles	0/20 cases	6/20 cases*
Madera	1/20	1/20
Riverside	5/20	0/20
Sonoma	4/20	2/20
Totals	**10/80 cases**	**9/80 cases†**
	13%	**11%**

Sources: California State Auditor's analysis of county records at welfare services and behavioral health departments.

* Because Los Angeles County used the same parameters before the State adopted them, we consider all Los Angeles County dosage exceptions as post-guidelines regardless of when they happened.

† Of these nine cases that exceeded the State's recommended guidelines (state guidelines), one case also occurred before the state guidelines. Therefore, 18 (23 percent) of the 80 foster children whose case files we reviewed were authorized to take psychotropic medications with maximum daily dosages that exceeded the state guidelines.

Although Social Services and Health Care Services consider the state guidelines to be best practices, they are of little value if counties do not use them. For example, six of the nine cases that occurred after the issuance of the state guidelines involved foster children in Los Angeles County. We find this surprising since the State adopted Los Angeles County's preexisting dosage standards as part of the state guidelines. In one of these instances, a physician prescribed an antidepressant medication for a foster child with a maximum daily dosage of 30 milligrams, which is 50 percent higher than the state guidelines' maximum recommended dosage of 20 milligrams. When we asked the medical director of LA Juvenile Court Services in Los Angeles' County's Department of Mental Health why county staff did not follow up with this provider, he explained that the county's practice has been to only review the actual daily dosage rather than the maximum daily dosage. However, he stated that county staff plan to monitor each prescription's maximum daily dosage moving forward.

Because a prescriber may include both an actual daily dosage and a maximum daily dosage when seeking court or parental authorization for a prescription, we are aware that some of the foster children we identified in our review may not have taken psychotropic medications in dosages that exceeded the state guidelines. However, we believe counties should question prescribers when they request maximum daily dosages that exceed the state guidelines because they may then choose to increase the children's dosage amounts up to the authorized maximum amounts without receiving additional review from the counties, the courts, or the children's parents.

Neither we nor the State can determine the extent statewide to which foster children's maximum daily dosages may exceed the state guidelines because the State does not capture data related to the maximum daily dosages of psychotropic medications that foster children are authorized to take. However, we believe it would be beneficial for the State to capture such information and compare it to the state guidelines. For example, such an analysis would allow the State to identify counties in which high proportions of foster children are being prescribed psychotropic medications in maximum daily dosages that exceed the state guidelines. This information would also allow the State to identify potentially problematic prescribing patterns so that it could follow up with the relevant counties. As discussed earlier, the Judicial Council recently adopted new and revised forms to request court authorization of psychotropic medications for foster children. These forms now require physicians to describe why they prescribed dosages that were outside the approved range. County staff can use this information to better ensure that foster children were properly prescribed psychotropic medications

Because the State lacks data on foster children's maximum authorized daily dosages of psychotropic medications, we compared the statewide data on prescribed daily dosages to the state guidelines' maximum dosage parameters. The state data show that in fiscal year 2014–15, 523 foster children had 2,389 prescriptions for psychotropic medications with prescribed daily dosages that exceeded the maximum allowable dosages in the state guidelines. These prescriptions represent nearly 2.5 percent of the 95,748 psychotropic medication prescriptions for that year. Although these numbers are fairly small, they indicate that some foster children received psychotropic medications in doses that exceeded the State's recommended maximum daily dosages, which put these children at higher risk of potentially dangerous side effects.

A Significant Number of the Foster Children We Reviewed Who Were Prescribed New Psychotropic Medications Did Not Receive Timely Follow-Up Visits With Prescribers or Other Health Care Providers

Our review of the 80 case files found that one-third of the foster children who were prescribed new psychotropic medications did not receive follow-up care with prescribers or other health care providers in a timely manner. Specifically, the academy guidelines state that providers should follow up with patients ideally within two weeks, but at least within a month, after they start psychotropic medications. Follow-up visits within 30 days are critical because adverse side effects from these medications are most common during the initial trial period. We excluded 13 cases from our analysis of follow-up visits because the foster children had been authorized to start all of their psychotropic medications before

Follow-up visits with prescribers or other health care providers within 30 days are critical because adverse side effects from psychotropic medications are most common during the initial trial period.

the start of our audit period. However, as Table 9 shows, we found no evidence in the county case files or the state data that one-third of the remaining 67 children had follow-up visits with their prescribers or other health care providers within 30 days of filling their prescriptions for psychotropic medication or receiving authorization to do so.[9]

Table 9
Cases in Which Counties Did Not Follow the American Academy of Child and Adolescent Psychiatry's Guidelines Regarding Follow-Up Appointments With Providers

COUNTY	NO EVIDENCE THAT PROVIDERS FOLLOWED UP WITHIN 30 DAYS AFTER A FOSTER CHILD STARTED A PSYCHOTROPIC MEDICATION
Los Angeles	2/16 cases
Madera	8/20
Riverside	7/19
Sonoma	6/12
Total	**23/67 cases**
	34%

Sources: California State Auditor's analysis of county records at welfare services and behavioral health departments, as well as data obtained from the Department of Health Care Services' Paid Claims and Encounters System.

Note: We excluded 13 cases from our analysis of follow-up visits because, in those cases, the foster children were authorized to start all of their psychotropic medications before our audit period. As a result, the foster children may have received follow-up appointments before the audit period.

One case in which a foster child did, in fact, have a follow-up meeting with a psychiatrist within 30 days of starting a higher dose of a psychotropic medication illustrates the importance of timely follow-up visits. About three weeks after starting the higher dose of the medication, the child complained of shaking hands and chest pain; on the advice of another doctor, the child stopped taking the medication. When the psychiatrist who had increased the medication dosage met with the foster child within 30 days as the academy guidelines recommend, the psychiatrist determined that the child's symptoms had greatly worsened since the child stopped taking the medication. In response, the psychiatrist restarted the child's medication but at a lower dosage. If this follow-up visit had not occurred or had been delayed, this child might have experienced worsening symptoms as a result of discontinuing the medication.

[9] Rather than using the ideal two-week time frame, we tested whether the foster children had a follow-up visit with their prescriber or other health care provider within 30 days because we lacked information about the exact dates that the children began taking the medications. Instead, we used the dates the prescriptions were filled or—if we did not have that information—we used the dates on which courts or parents authorized the medications. The 30-day time frame allows a two-week buffer in case children did not begin taking the medication immediately after the prescriptions were filled or authorized.

Three of the four counties we visited offered similar explanations for the fact that so many foster children did not receive timely follow-up care. For example, a division chief in Los Angeles County's Department of Children and Family Services indicated that the department supports follow-up appointments with providers within 30 days (or sooner, if indicated) for all foster children on psychotropic medications. However, she also noted that the limited number of child psychiatrists who accept Medi-Cal-insured clients may explain why some foster children did not receive a follow-up visit with their prescriber within 30 days of starting their medication. Similarly, a division manager within Madera County Behavioral Health Services noted that the limited number of child and adolescent psychiatrists make it difficult for small counties to schedule follow-up visits with these prescribers. The Sonoma County Behavioral Health Division's medical director also agreed that it is reasonable for psychiatrists to arrange follow-up visits within 30 days of foster children's starting psychotropic medications and stated that the county is in the process of revising its policies to adhere to the academy guidelines as closely as possible.

On the other hand, Riverside County Behavioral Health's medical director stated that child and adolescent psychiatrists are trained extensively in their field and that the county defers to the individual prescriber's discretion regarding any follow-up on a foster child's medications. However, we believe that counties that defer to individual providers are missing an opportunity to better protect the foster children under their care. Unless counties ensure that all foster children who start new psychotropic medications receive follow-up visits with their prescribers within 30 days, they cannot be certain that the prescribers will monitor the children for potential adverse side effects.

We believe that counties that defer to an individual prescriber's discretion regarding any follow-up on a foster child's medications are missing an opportunity to better protect the foster children under their care.

The state data show that the lack of appropriate follow-up care appears to be a statewide problem. As Table 10 illustrates, 1,881 (29 percent) of the 6,471 foster children statewide had filled prescriptions for a new psychotropic medication in fiscal year 2013–14 without a corresponding Medi-Cal claim for a follow-up service within 30 days after the prescription was filled. We acknowledge that in some of these cases, the foster child may not have shown up for a scheduled follow-up appointment. The state data show that Los Angeles County had follow-up appointment rates that were better than the statewide statistics by 14 percentage points. They also indicate that 41 and 51 percent of the foster children in Riverside and Sonoma counties who had a filled prescription for a new psychotropic medication did not have a corresponding Medi-Cal claim for a follow-up service within 30 days after the prescription was filled. Further, although the state data show that the rate of foster children who had a

filled prescription for a new psychotropic medication without a corresponding follow-up medication service within 30 days after the prescription was filled is 29 percent throughout the state, 15 of the counties referred to in Table A-8 beginning on page 90 in the Appendix had rates that exceeded 50 percent. However, the state data only cover services provided through Medi-Cal, and some of the children may have received follow-up services outside of Medi-Cal. We discuss this issue further in Chapter 2.

As discussed earlier, the Judicial Council recently adopted new and revised forms to request court authorization of psychotropic medications for foster children. These forms now require county staff to list the dates of all medication management appointments since the last court hearing. County staff can use this information to better ensure that foster children were properly prescribed psychotropic medications.

Table 10

Number and Proportion of Children in Foster Care With New Psychotropic Medication Prescriptions Filled in Fiscal Year 2013–14 Without a Corresponding Medi-Cal Claim for a Follow-Up Medication Service Within 30 Days, Statewide and for Four Counties

	NUMBER OF FOSTER CHILDREN WITH NEW PSYCHOTROPIC MEDICATION PRESCRIPTIONS*	NUMBER OF FOSTER CHILDREN WITH AT LEAST ONE FILLED PRESCRIPTION FOR A NEW PSYCHOTROPIC MEDICATION WITHOUT A CORRESPONDING MEDI-CAL CLAIM FOR FOLLOW-UP MEDICATION SERVICES	
		NUMBER	PERCENT
Statewide	6,471	1,881	29.1%
Counties We Visited			
Los Angeles	2,252	334	14.8%
Madera	17	†	†
Riverside	406	167	41.1
Sonoma	90	46	51.1

Sources: California State Auditor's analysis of data obtained from the Department of Health Care Services' Paid Claims and Encounters System, data obtained from the California Department of Social Services' Child Welfare Services/Case Management System, and matched Medi-Cal pharmacy data.

Note: The term *foster children* refers to children aged zero to 17 in the foster care system.

* We defined a *new prescription* as any prescription for a psychotropic medication that the child had not been prescribed in the prior 120 days and, as discussed in the Scope and Methodology section on page 17, we applied the National Committee for Quality Assurance's methodology for follow-up care.

† To protect individual privacy, we omitted this number because it would identify 10 or fewer foster children. Such omission is in accordance with aggregate data reporting guidelines issued by the Department of Health Care Services.

Many of the State's Foster Children Who Were Prescribed Psychotropic Medications May Not Have Received Corresponding Psychosocial Services

Both the academy and state guidelines emphasize the importance of providing foster children with alternative treatments in addition to psychotropic medications. Specifically, the academy guidelines point out that, while many youth benefit from psychotropic medications used as part of a comprehensive treatment plan, this plan should include nonmedication interventions as well, if appropriate. In fact, the academy guidelines caution that medication may be overprescribed when insufficient attention is paid to other supports and services, such as psychosocial treatments.[10] The academy guidelines also state that actively pursuing alternative interventions is especially important when the medications can have serious side effects and are prescribed over an extended period of time. Similarly, the state guidelines indicate that psychotropic medications should be used in conjunction with psychosocial services. According to the state guidelines, the only exception is when a health care provider terminates a child's psychosocial services because they have been effective but the provider determines that the continued use of medication is necessary to prevent the recurrence of symptoms.

Traditionally, psychosocial services are recommended before pharmacological treatment. However, the academy guidelines acknowledge that pharmacological treatments can be initiated before, concurrent with, or after psychosocial services, depending on the available research evidence and needs of the patient. For example, randomized controlled trials suggest that medication management for attention-deficit/hyperactivity disorder should be the first-line treatment, while medication combined with behavioral treatment may be necessary for optimal outcomes for a child with more complex problems. Conversely, for obsessive-compulsive disorder, the best first option is either cognitive-behavioral therapy, especially if delivered by an expert psychotherapist, or combined treatment (i.e., therapy and medication). However, the academy guidelines also note that although empirically supported psychosocial treatments may be the optimal first step for many disorders, many communities lack skilled providers of such treatments. In these communities, starting treatment with medication may be the best intervention available.

We found that many foster children may not have received psychosocial services before and after starting psychotropic medications.

Despite the importance of psychosocial services to children's overall treatment plans, we found that many foster children may not have received such services before and after starting psychotropic medications. We reviewed the case files of 67 foster

[10] Psychosocial treatments can include behavioral health counseling and therapy, therapeutic behavioral services, crisis intervention, and services provided in a psychiatric health facility.

children at the four counties we visited to determine whether they received psychosocial services before and after starting new psychotropic medications. Because the foster children may have received psychosocial services that the counties did not adequately document in their case files, we also analyzed the State's Medi-Cal data for these children to determine whether the Medi-Cal program paid for their psychosocial services. As Table 11 illustrates, our analysis found that between 9 and 15 percent of the 67 foster children did not receive psychosocial services six months before starting psychotropic medications. Furthermore, this evidence also indicates that between 4 and 7 percent of the 67 foster children did not receive psychosocial services within six months after starting medications.

Table 11
Cases in Which Children in Foster Care Prescribed Psychotropic Medications Did Not Receive Corresponding Psychosocial Services

	NO PSYCHOSOCIAL SERVICES WITHIN 6 MONTHS...		OF THOSE CASES THAT RECEIVED PSYCHOSOCIAL SERVICES WITHIN 6 MONTHS...	
COUNTY	...BEFORE STARTING AT LEAST ONE PSYCHOTROPIC MEDICATION, BASED ON COUNTY RECORDS AND STATE DATA	...AFTER STARTING AT LEAST ONE PSYCHOTROPIC MEDICATION, BASED ON COUNTY RECORDS AND STATE DATA	...BEFORE, THE NUMBER THAT DID NOT RECEIVE THOSE SERVICES WITHIN 30 DAYS BEFORE STARTING AT LEAST ONE MEDICATION, BASED ON COUNTY RECORDS AND STATE DATA	...AFTER, THE NUMBER THAT DID NOT RECEIVE THOSE SERVICES WITHIN 30 DAYS AFTER STARTING AT LEAST ONE MEDICATION, BASED ON COUNTY RECORDS AND STATE DATA
Los Angeles	1/16–2/16 cases	0/16–1/16 cases	0/15–1/14 cases	0/16–0/15 cases
Madera	3/20–4/20	0/20	4/17–5/16	7/20–8/20
Riverside	1/19–2/19	1/19–2/19	3/18–4/17	3/18–4/17
Sonoma	1/12–2/12	2/12	4/11–3/10	4/10
Totals	**6/67–10/67 cases***	**3/67–5/67 cases***	**11/61–13/57 cases†**	**14/64–16/62 cases‡**
	9–15 percent	**4–7 percent**	**18–23 percent**	**22–26 percent**

Sources: California State Auditor's analysis of county records at welfare services and behavioral health departments, as well as data obtained from the Department of Health Care Services' Paid Claims and Encounters System.

Note: As described on page 41, we report a range in the number of foster children who did not receive timely psychosocial services because of differences in the procedure codes used by the National Committee for Quality Assurance and the Department of Health Care Services to identify psychosocial services.

* We excluded 13 cases from these analyses because, in those cases, the foster children were authorized to start all of their psychotropic medications before our audit period. Therefore, the services may have occurred outside the audit period and we did not review the documentation.

† We excluded a number of cases from this analysis because the foster children were either authorized to start all of their psychotropic medications before our audit period or because the foster children did not have psychosocial services within six months before starting at least one of their psychotropic medications.

‡ We excluded a number of cases from this analysis because the foster children were either authorized to start all of their psychotropic medications before our audit period or because the foster children did not have psychosocial services within six months after starting at least one of their psychotropic medications.

In addition, counties may not be ensuring that foster children receive the optimal care if those children do not promptly receive the necessary psychosocial services. We evaluated whether the foster children whose files we reviewed received services within 30 days of starting psychotropic medications. As Table 11 shows, of the foster children who had received psychosocial services within

the six months before starting psychotropic medications and who started at least one psychotropic medication within our audit period, we found that between 18 and 23 percent did not receive these psychosocial services within 30 days before starting their medications. Of the foster children who received psychosocial services within six months after starting medications and who started at least one psychotropic medication within our audit period, the evidence suggests that between 22 and 26 percent did not receive those services within the first 30 days of starting the medications.

When we reviewed the state data to determine the extent to which foster children statewide who had a filled prescription for psychotropic medications also received supporting psychosocial services, we found that between 3,965 and 7,489 (41 to 77 percent) of the 9,707 foster children with paid prescriptions for psychotropic medications in fiscal year 2013–14 did not receive corresponding psychosocial services through Medi-Cal both 30 days before and 30 days after receiving psychotropic medications, as shown in Table 12.[11]

Table 12
Number of Children in Foster Care With Filled Prescriptions for Psychotropic Medications Without a Corresponding Medi-Cal Claim for Psychosocial Services, Statewide and for Four Counties, Fiscal Year 2013–14

	FOSTER CHILDREN WITH FILLED PRESCRIPTIONS FOR PSYCHOTROPIC MEDICATIONS	NUMBER OF FOSTER CHILDREN WITH AT LEAST ONE INSTANCE OF NO SERVICE WITHIN...	
		...30 DAYS BEFORE OR AFTER, FILLING A PRESCRIPTION	...180 DAYS BEFORE OR AFTER, FILLING A PRESCRIPTION
Statewide	9,707	3,965–7,489	1,564–4,512
Counties We Visited			
Los Angeles	3,267	742–2,185	204–994
Madera	23	*	*
Riverside	600	385–556	146–363
Sonoma	142	98–*	56–98

Sources: California State Auditor's analysis of data obtained from the Department of Health Care Services' Paid Claims and Encounters System, data obtained from the California Department of Social Services' Child Welfare Services/Case Management System, and matched Medi-Cal pharmacy data.

Note: The term *foster children* refers to children aged zero to 17 in the foster care system. In addition, as described on page 41, we report a range in the number of foster children who did not receive timely psychosocial services because of differences in the procedure codes used by the National Committee for Quality Assurance and the Department of Health Care Services to identify psychosocial services.

* To protect individual privacy, we omitted this number because it would identify 10 or fewer foster children. Such omission is in accordance with aggregate data reporting guidelines issued by the Department of Health Care Services.

[11] To determine an approximate start date for the psychotropic medications, we used the date the medication was filled at the pharmacy.

We report a range in the number of foster children who did not receive psychosocial services because of differences in the way psychosocial services are identified in the state data. We based the high estimate in our range on the definition of psychosocial services contained in the Healthcare Effectiveness Data and Information Set (HEDIS), a set of health care performance measures developed by the National Committee for Quality Assurance and used by more than 90 percent of the health care plans in the United States. However, Health Care Services uses an expanded version of the HEDIS definition of psychosocial services—which includes services provided by certain mental health professionals and billed as comprehensive community support services or provided at federally qualified health centers or rural health clinics—which is reflected in the low estimate in our range. The chief medical information officer of Health Care Services noted that the HEDIS definition does not count community support services as psychosocial services. However, she stated that mental health professionals such as psychiatrists and licensed clinical social workers provide most of the community support services in California and should therefore be counted as a psychosocial service. Further, the services provided at federally qualified health centers or rural health clinics that Health Care Services includes in its definition are provided by this same group of mental health professionals. Consequently, our analysis estimates the likely range in which foster children who took psychotropic medications also received psychosocial services through the Medi-Cal program based on both the HEDIS and Health Care Services' definition of psychosocial services.

In addition, the state data used in our analysis only include those services for which Medi-Cal paid and does not include services paid for outside of Medi-Cal. Further, although children may enter and exit the foster care system on multiple occasions over time, we did not adjust our calculations to account for this. Information from the California Child Welfare Indicators Project for 2013 indicated that 75 percent of foster children had lengths of stay in their last foster care placement of 7.7 months or longer.[12]

The Judicial Council of California (Judicial Council) adopted new and revised forms—which became effective in July 2016—that providers must use to request court authorization of psychotropic medications for foster children.

Finally, as discussed earlier, the Judicial Council adopted new and revised forms to request court authorization of psychotropic medications for foster children. These forms place an increased emphasis on the provision of psychosocial services to these children. For example, the forms now require prescribing physicians to provide more detailed information about the psychosocial services foster children previously received. In addition, the forms now require social workers and probation officers to identify the specific

[12] The California Child Welfare Indicators Project is a collaborative venture between the University of California, Berkeley School of Social Work and Social Services that makes available child welfare administrative data to policymakers, child welfare workers, and the public on a website.

psychosocial services that foster children received in the past six months, as well as to indicate the types of therapeutic services the children are enrolled in or are recommended to participate in during the next six months.

Although the Judicial Council's changes to the court authorization forms place increased emphasis on the psychosocial services provided to foster children, we believe additional steps are necessary. Specifically, counties must develop and implement stronger procedures to ensure that foster children who are prescribed psychotropic medications consistently receive corresponding psychosocial services. In addition, the counties must adequately document these services so that caregivers can better monitor the children, as we will discuss in further detail in Chapter 2.

In Violation of State Law, More Than a Third of the Foster Children We Reviewed Received At Least One Prescription for Psychotropic Medications Without Required Court Approval or Parental Consent

Information Required With Applications for Court Authorization to Administer Psychotropic Medications

- A description of the child's psychiatric diagnosis to be treated with the medication.
- The proposed medication to be administered along with a maximum daily dosage and length of time for the course of treatment.
- The anticipated benefits and possible side effects associated with using the medication.
- A list of any other drugs that the child is currently taking and a description of any effect these drugs may produce in combination with the psychotropic medication.
- A description of any other therapeutic services related to the child's mental health status.
- A statement that the child has been informed in an age-appropriate manner of the recommended course of treatment, the basis for it, and its possible results, along with the child's response to the information.

Source: California Rules of Court, Rule 5.640, in effect before July 2016 for the period covered by our testing.

Counties do not always obtain required court or parental approval before foster children receive psychotropic medications. As previously discussed, state law requires that juvenile courts either authorize the administration of psychotropic medications for foster children or delegate that authority to the children's parents upon findings on the record that the parents pose no danger to the children and have the capacity to authorize psychotropic medications. Although California rules of court allow for the administration of psychotropic medications without prior court authorization in emergency situations, even in emergency situations physicians must seek authorization no more than two "court days" after administering the medications.

A physician seeking court authorization to prescribe a psychotropic medication to a foster child must submit the application forms developed by the Judicial Council for that purpose. As shown in the text box, the application must include a number of items to help the court decide how to adjudicate the request. A parent or guardian, or others as allowed by the court's rules, may file an opposition to the request with the court. Based on the information in the application and any opposition to the request, the court may grant authorization without a hearing. Alternatively, it can schedule a hearing, at which it

may grant, deny, or modify the application. At that time, it may also set a date for review of the child's progress and condition. A court order to authorize a psychotropic medication is effective for 180 days unless the court terminates or modifies it sooner.

However, when we reviewed the 80 case files we selected, we found that more than a third of the foster children had at least one prescription for psychotropic medications without court authorization or parental consent. Specifically, 23 (34 percent) of the case files of the 67 foster children who should not have received psychotropic medications without court approval lacked evidence of such approval for at least one of the psychotropic medications that the child was prescribed, as shown by Table 13. For example, we identified one foster child who was prescribed both an antipsychotic medication and an antidepressant medication without receiving prior court approval. Further, five (38 percent) of the case files for 13 foster children who should have received parental consent before taking psychotropic medications lacked evidence of consent for at least one of the psychotropic medications prescribed for the child. In fact, one of these case files did not contain evidence of parental consent for six of the child's psychotropic medications.

Table 13
Counties Did Not Always Have Approvals for Psychotropic Medications Prescribed to Children in Foster Care

COUNTY	NO DOCUMENTATION OF COURT AUTHORIZATION FOR AT LEAST ONE PSYCHOTROPIC MEDICATION PRESCRIPTION	NO DOCUMENTATION OF PARENTAL CONSENTS FOR AT LEAST ONE PSYCHOTROPIC MEDICATION PRESCRIPTION	LATE COURT AUTHORIZATION FOR AT LEAST ONE PSYCHOTROPIC MEDICATION PRESCRIPTION*	PRESCRIPTION FOR PSYCHOTROPIC MEDICATION FILLED PRIOR TO AUTHORIZATION
Los Angeles	8/18 cases	2/2 cases	4/18 cases	2/20 cases
Madera	6/20	0/0	6/20	3/20
Riverside	6/20	0/0	7/20	3/20
Sonoma	3/9	3/11	3/9	4/20
Totals	**23/67 cases**	**5/13 cases**	**20/67 cases**	**12/80 cases**
	34%	**38%**	**30%**	**15%**

Sources: California State Auditor's analysis of county records at welfare services and behavioral health departments, as well as data obtained from the Department of Health Care Services' Paid Claims and Encounters System.

* We defined late court authorizations as either counties not obtaining a renewed court authorization within 180 days for continuing psychotropic medications, or not seeking a court authorization within two court days of the emergency administration of psychotropic medications to a foster child.

Further, we attempted to compile statewide data, however Social Services' data is not formatted in a way that allows us to definitively identify if court authorizations or parental consents are associated with a specific psychotropic medication. As a result, we analyzed the statewide data to identify the frequency with which court authorizations or parental consents existed for any medication and if that consent was either 180 days before or 30 days after

the psychotropic medication prescription was filled. As Table 14 illustrates, more than 65 percent of the 9,317 foster children that the state data show as having had paid prescriptions for psychotropic medications in fiscal year 2014–15 were prescribed at least one psychotropic medication for which Social Services' data system lacks any record of court or parental approval. In fact, more than 3,400 (37 percent) of these children had no court authorization or parental consent recorded in Social Services' data system for any of their psychotropic medications. These outcomes were even more pronounced at the four counties we reviewed—more than 20 percent to nearly 78 percent of the prescriptions at these counties lacked records of consent. We acknowledge that both the counties' case files and the state data related to court authorizations and parental consents may be incomplete; in fact, we discuss the deficiencies in the state data in Chapter 2. Nonetheless, our analyses strongly suggest that a sizeable number of foster children were prescribed psychotropic medications without prior court authorization or parental consent.

Table 14
Number and Proportion of Children in Foster Care With Filled Prescriptions for Psychotropic Medication by Type of Approval Recorded in Social Services' Data, Statewide and for Four Counties, Fiscal Year 2014–15

		TYPES OF CONSENT					
	TOTAL NUMBER OF FOSTER CHILDREN WITH FILLED PRESCRIPTIONS FOR PSYCHOTROPIC MEDICATIONS	COURT AUTHORIZATION OR PARENTAL CONSENT FOR ALL PSYCHOTROPIC MEDICATIONS		NO COURT AUTHORIZATION OR PARENTAL CONSENT FOR ANY PSYCHOTROPIC MEDICATIONS		NO COURT AUTHORIZATION OR PARENTAL CONSENT FOR ONE OR MORE PSYCHOTROPIC MEDICATIONS	
		NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Statewide	9,317	3,232	34.7%	3,448	37.0%	6,085	65.3%
Counties We Visited							
Los Angeles	3,194	920	28.8%	1,475	46.2%	2,274	71.2%
Madera	21	*	*	*	*	*	*
Riverside	595	300	50.4	121	20.3	295	49.6
Sonoma	140	31	22.1	65	46.4	109	77.9

Sources: California State Auditor's analysis of data obtained from the California Department of Social Services' Child Welfare Services/Case Management System and matched Medi-Cal pharmacy data.

Notes: The term *foster children* refers to children aged zero to 17 in the foster care system.

* To protect individual privacy, we omitted this number because it would identify 10 or fewer foster children. Such omission is in accordance with aggregate data reporting guidelines issued by the Department of Health Care Services.

We also found that the counties we visited did not always obtain court authorizations for psychotropic medications in a timely manner. As previously mentioned, court authorizations for psychotropic medications are only effective for up to 180 days. For a foster child to continue to receive a psychotropic medication after six months, the county must seek to renew the court's authorization. Furthermore, a foster child in an emergency situation may take psychotropic medications without an authorization;

however, the court must receive a request for authorization within two days after the child starts the medication. If counties do not seek court authorization within two days, the foster child is taking psychotropic medications without proper approval. However, our review of the case files for the 67 children who required court authorization for their psychotropic medications found that 20 (30 percent) contained court authorizations that counties had obtained from 12 days to more than seven months late. In fact, in one case, Madera County renewed the court's authorization for three of a child's medications seven months late. In this instance, staff stated that the county opposed one of the proposed medications, and because of delays in the process, the county never followed up to ensure the other requested medications were approved. When counties do not seek to obtain court approvals in a timely manner, they deprive courts of the opportunity to assess whether ongoing psychotropic medications are necessary and safe for foster children to receive.

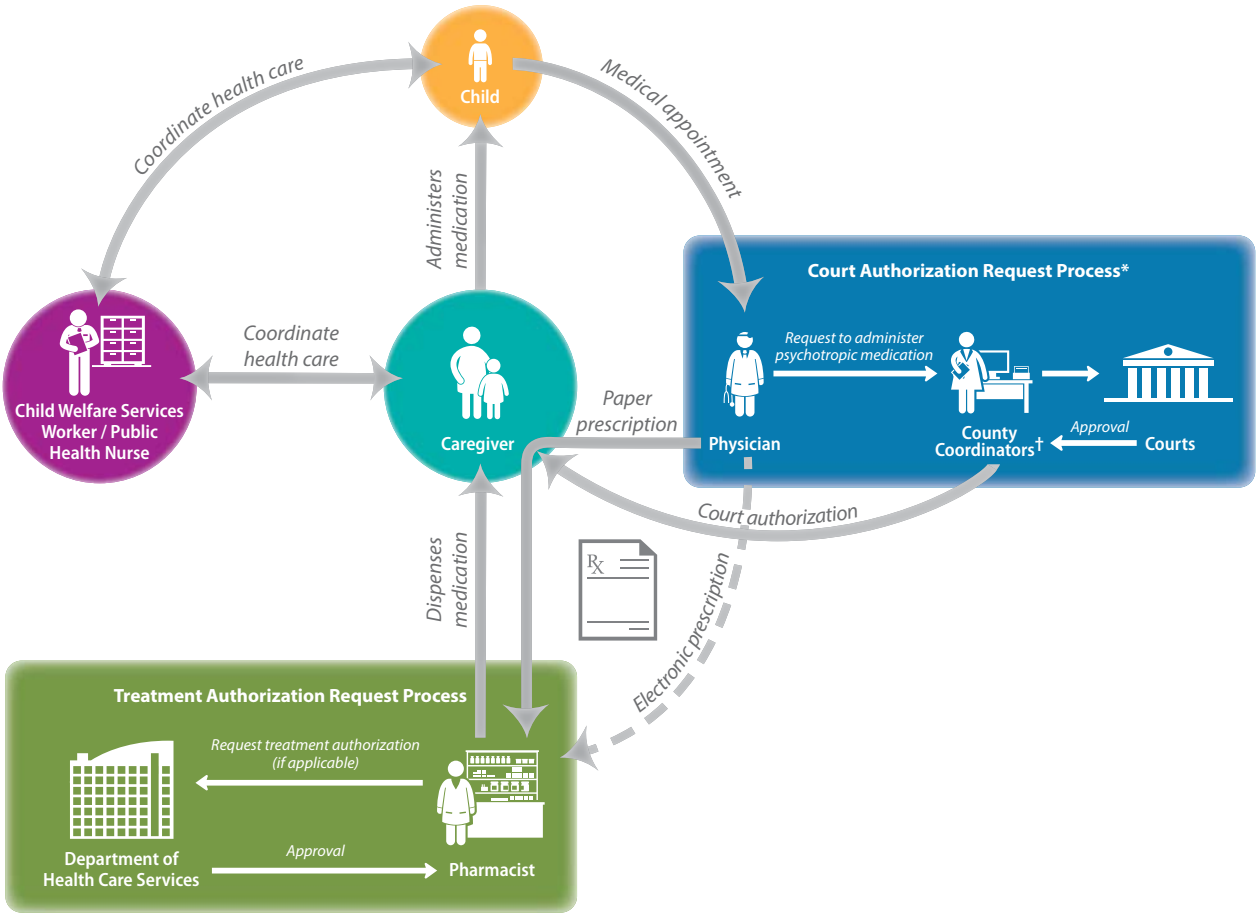
Moreover, weaknesses in the court and parental authorization processes could lead to foster children receiving psychotropic medications before the prescriptions are approved. For example, as Figure 3 on the following page shows, the processes used at the four counties we visited allow providers to write prescriptions for psychotropic medications at the same time they request authorization from the courts or parents. The caregivers of the foster children could then take the prescriptions to pharmacies to be filled. In fact, 12 (15 percent) of 80 case files we reviewed contained instances in which foster children's caregivers filled their prescriptions before they were authorized. When we asked what mechanisms prevent children from taking their medications without the necessary authorizations, staff at three of the counties asserted that their caregivers are responsible for ensuring that they administer the psychotropic medications only after the prescriptions are authorized. Alternatively, Madera County Social Services' deputy director stated that he believes social workers are ultimately responsible for ensuring that foster children do not take psychotropic medications that are not yet approved.

Better safeguards are necessary to prevent children from taking psychotropic medications without the legally required approvals.

Given the results of our case file review, we believe that better safeguards are necessary to prevent children from taking psychotropic medications without the legally required approvals. For example, counties could create a process in which the caregiver notifies a foster child's social worker or public health nurse when the child is ready to start a psychotropic medication. The social worker or public health nurse could then determine whether court or parental authorizations exist for the medication, and inform the caregiver about whether the foster child can start the psychotropic medication. This process would also allow counties to obtain more accurate medication start dates, an issue that we discuss in

Chapter 2. By ensuring that caregivers know when to properly administer psychotropic medications to their foster children, counties can gain better assurance that foster children do not take psychotropic medications before those prescriptions are approved.

Figure 3
Psychotropic Medication Oversight of Children in Foster Care



Sources: California State Auditor's analysis of state laws and regulations, county policies and procedures, and interviews with county officials at Los Angeles, Madera, Riverside, and Sonoma counties.

Note: We use the term *foster children* to refer to children aged zero to 17 in the foster care system.

* The court may delegate its authority to administer psychotropic medications to a foster child's parents, which removes the court authorization process.

† County coordinators include social workers, probation officers, public health nurses, and other county staff who coordinate gathering the court authorization request documents to provide to the courts.

Because most counties we visited identified the caregiver as the point of control in the administration of psychotropic medications to foster children, the entity that oversees the caregivers should logically be responsible for providing instructions related to those medications' authorization. Social Services' Community Care Licensing Division—specifically, its Children's Residential Licensing

Program (Licensing Program)—issues licenses to homes and facilities that house foster children and performs inspections of those homes to ensure they provide a safe and healthy environment. The Licensing Program created a medications guide specific to group homes that includes detailed information concerning psychotropic medication use and explains the court authorization process. According to a program manager, the Licensing Program posted this medication guide on its website on December 31, 2015. She indicated that the Licensing Program is currently creating a similar guide for foster family agencies and homes. By issuing clear, detailed instructions to caregivers in all types of facilities, the State can better ensure that foster children do not receive psychotropic medications without or before approval.

Two of the counties we reviewed also recently implemented processes that may help mitigate the issues we found related to missing or late court authorizations. Specifically, in July 2015, Riverside County hired a public health nurse whose primary responsibility is to monitor and ensure compliance with the court authorization process at both a case level and a systemic level. The public health nurse produces a monthly report for Riverside County's Department of Social Services summarizing the number of court authorizations that have lapsed without renewals. Similarly, in November 2015 Sonoma County started to track expiring court authorizations and parental consents to help ensure foster children have current approvals for psychotropic medications. A program development manager from Sonoma County Family, Youth and Children Division creates monthly summary reports of foster children prescribed psychotropic medications from Social Services' Child Welfare Service Case Management System and provides the reports to social worker supervisors and their managers for follow up.

Despite Sonoma County's recent positive steps, we remain concerned about its problematic practices for obtaining parental consent for psychotropic medications. As mentioned earlier, Sonoma County used parental consent far more frequently than most other counties in fiscal year 2014–15. Sonoma County told us that its use of parental consent is in line with its local legal culture to keep parents involved in their children's lives. Consequently, its social workers generally advocate to the court to delegate authorization of psychotropic medications to the parents. As a result, Social Services' data show that most counties recorded parental consent for 1 percent or less of their foster children, whereas Sonoma County recorded parental consent for more than 20 percent.

Most counties recorded parental consent for 1 percent or less of their foster children, whereas Sonoma County recorded parental consent for more than 20 percent.

According to a deputy director at Social Services, a county may have valid reasons for having parents consent for a foster child's psychotropic medications. However, Sonoma County currently does not follow its policy related to obtaining parental consent for psychotropic medications. Specifically, the Sonoma County Family, Youth and Children Division purportedly operates under a 16-year-old policy related to parental consent, first adopted in response to the statutes that established the requirement. Among other things, the policy states that social workers will mail parents copies of physician recommendations for medications along with consent forms—a process that would clearly document the request for medications and the parents' consent. However, according to a Sonoma County division director, the county does not follow this policy. Instead, prescribing physicians must work with the parents directly to obtain their informed consent. This process seems problematic, since it is unclear how physicians would know whom to contact if caregivers bring the children to appointments. Contrary to what the department director indicated, a program manager stated the county's practice is that social workers obtain parental consent, verbal or otherwise, and then record the consent into Social Services' data system every six months.

Recommendations

Counties

To better ensure that foster children only receive psychotropic medications that are appropriate and medically necessary, counties should take the following actions:

- Implement procedures to more closely monitor requests for authorizations for foster children's psychotropic medications that exceed the state guidelines for multiple prescriptions, specific age groups, or dosage amounts. When prescribers request authorizations for prescriptions that exceed the state guidelines, counties should ensure the new court authorization forms contain all required information and, when necessary, follow up with prescribers about the medical necessity of the prescriptions. Counties should also document their follow-up monitoring in the foster children's case files. In instances in which counties do not believe that prescribers have adequate justification for exceeding the state guidelines, the counties should relay their concerns and related recommendations to the courts or parents.

- Ensure that all foster children are scheduled to receive a follow-up appointment within 30 days of starting a new psychotropic medication.

- Implement processes to ensure that foster children receive any needed mental health, psychosocial, behavioral health, or substance abuse services before and concurrently with receiving psychotropic medications.

- Implement a systemic process for ensuring that court authorizations or parental consents are obtained and documented *before* foster children receive psychotropic medications and that court authorizations for psychotropic medications are renewed within 180 days as state law requires. The process should also ensure that the counties better document the court authorizations and parental consents in the foster children's case files.

- Develop and implement a process for county staff and caregivers to work together to ensure the psychotropic medications are authorized before being provided to foster children. This process should also ensure that the counties obtain accurate medication start dates from caregivers.

Riverside County

To improve its oversight of foster children who are prescribed psychotropic medications, Riverside County should take the following actions:

- Immediately adopt the state guidelines for its physicians' use when prescribing psychotropic medications and for the county's use when reviewing court authorization requests.

- Continue to use its new tracking process to better ensure that court authorizations are renewed within 180 days.

Sonoma County

To improve its oversight of foster children prescribed psychotropic medications, Sonoma County should take the following actions:

- Immediately adopt the state guidelines for its physicians' use when prescribing psychotropic medications and the county's use when reviewing court authorization requests.

- Within six months, implement a process to review psychotropic medications that receive parental consent rather than court authorization.

- Update its policies to describe methods for obtaining and documenting in the foster children's case files parental consents for psychotropic medications.

California Department of Social Services

To better ensure that counties only use parental consent in place of court authorization when it is appropriate, Social Services should assess Sonoma County's practice of advocating to the juvenile court that it delegate to parents the authority to administer psychotropic medications to foster children.

To better ensure that all caregivers are informed and educated regarding the use of psychotropic medications and the court authorization process, Social Services should develop instructions regarding these topics and provide them to caregivers, such as foster family agencies, that do not operate group homes.

Chapter 2

FRAGMENTED OVERSIGHT AND POOR DATA HAVE HAMPERED STATE AND COUNTY EFFORTS TO ENSURE THE APPROPRIATE PRESCRIBING OF PSYCHOTROPIC MEDICATIONS TO CHILDREN IN FOSTER CARE

Chapter Summary

As described in the Introduction, California's current government structure for overseeing psychotropic medications prescribed to children in foster care (foster children) is fragmented, with state and local executive and judicial branch entities performing various functions. Although these entities have made some efforts to collaborate, the State's approach provides little system-level oversight to help ensure that the entities' efforts actually work as intended. Further, the State has not developed a comprehensive oversight plan that identifies each of its various oversight mechanisms and describes how these mechanisms should work together.

The State's fragmented oversight structure has contributed to the problems we identified in Chapter 1 and has led to other weaknesses in the monitoring of foster children's psychotropic medications as well. For instance, at the four counties we visited, many foster children's Health and Education Passports—critical health summary documents that follow foster children should their placement change—contained omissions and errors in their health information. Specifically, the Health and Education Passports for all 80 of the foster children whose case files we reviewed had incorrect start dates for psychotropic medications. Further, many of these Health and Education Passports did not identify all the psychotropic medications that the courts authorized, and none contained complete summaries of the psychosocial services that the foster children had received. When Health and Education Passports contain inaccurate and incomplete health information, health care providers and caregivers may not have critical information that they need to make sound health care decisions for the foster children in their care. Further, inaccurate and incomplete information hampers the State's and counties' oversight efforts.

We also found weaknesses in the State's oversight of the counties, physicians, and pharmacists who are involved with foster children's mental health care. The California Department of Social Services (Social Services) only recently began examining psychotropic medications prescribed to foster children through its California Child and Family Services Reviews (California reviews) of the counties. Further, the Medical Board of California (Medical Board) does not currently take steps to proactively identify

physicians for further investigation who might have inappropriately prescribed psychotropic medications to foster children. Finally, the Department of Health Care Services (Health Care Services) has not programmed its claims system to prompt pharmacists to submit treatment authorization requests for psychotropic medications that are prescribed for off-label use—a use that has not been approved by the U.S. Food and Drug Administration—to ensure the prescriptions' medical necessity. Due to its insufficient oversight, the State has reduced assurance that health care providers are reasonably prescribing psychotropic medications to foster children.

The Fragmented Structure of California's Child Welfare System Has Contributed to Weaknesses in the Oversight of the Prescription of Psychotropic Medications to Foster Children

We believe that the fragmented structure of California's child welfare system lessens the State's assurance that psychotropic medications are appropriately prescribed to foster children. As the Introduction explains, oversight of psychotropic medications prescribed to foster children is diffused among multiple government levels and branches. Consequently, executive and judicial branch agencies at the state and local levels share responsibilities for administering and overseeing different aspects of the provision of psychotropic medications to foster children. However, by increasing their current levels of collaboration, the various government agencies involved in child welfare services could improve their oversight and better address many of the problems we discuss later in this chapter and in Chapter 1.

California's oversight approach for its administration of foster care and monitoring of psychotropic medications appears to be piecemeal with little system-level oversight to help ensure that the collective oversight efforts produce measureable, desirable results.

Given the splintered nature of California's administration of foster care and oversight of psychotropic medications for foster children, we expected to find that the State had a comprehensive oversight plan. Ideally, this plan would describe the State's various oversight mechanisms, the public entities responsible for employing those mechanisms, and the tools in place to ensure that these entities work individually and collectively to ensure that psychotropic medications are prescribed properly to foster children. However, we found no such plan. Despite some collaborative efforts of the public entities involved, California's oversight approach to date appears to be piecemeal with little system-level oversight to help ensure that the collective oversight efforts produce measureable, desirable results.

Social Services created the closest thing to a comprehensive plan that we were able to identify. Specifically, Social Services summarized certain existing efforts to oversee the prescription of psychotropic medications to foster children as part of its 2015–2019 Child and Family Services Plan (state plan) required

by the federal government. Within this state plan, Social Services included a section covering the oversight of prescription medicines, including psychotropic medications. Social Services identified four critical components of the State's oversight of prescription medicines:

- Public health nurses, who are responsible for ensuring that foster children have current records of their prescribed medications and that their medication information is documented in their Health and Education Passports and in Social Services' Child Welfare Services/Case Management System (Social Services' data system), as we will discuss later in this chapter.

- Juvenile courts, which are responsible for authorizing prescriptions for psychotropic medications for foster children.

- The Quality Improvement Project, which began in 2012 and whose goals include reducing the inappropriate prescribing of multiple psychotropic medications to foster children and supporting the use of psychosocial services in lieu of medications.

- Outcome Measure 5F, which uses information recorded in Social Services' data system to track the proportion of foster children for whom the courts have authorized psychotropic medications.

Although these components may play a role in the oversight of the prescription of psychotropic medications to foster children, they do not as a whole represent the sort of comprehensive, systemwide effort that could best ensure that children do not receive these medications unnecessarily.

Other states have taken more streamlined approaches to their oversight of psychotropic medications prescribed to foster children. According to its 2015–2019 Child and Family Services Plan, Texas has dedicated specialized staff within its Department of Family and Protective Services to coordinate and oversee health care services for foster children, including a medical director who is a child and adolescent psychiatrist and who coordinates with Texas' health care plan to ensure the appropriate prescribing of psychotropic medications. In contrast to California, which provides psychosocial services through multiple Medi-Cal mental health plans, various Medi-Cal managed care plans, and fee-for-service providers, its Child and Family Services Plan states that Texas contracts with a single health plan in which all Texas foster children are enrolled. Further, Texas requires the health plan to oversee the administration of psychotropic medications to foster children to ensure compliance with that state's requirements. These requirements identify utilization parameters, maximum dosage amounts, warnings about side effects, and nine criteria that trigger

In contrast to California, which provides psychosocial services through multiple Medi-Cal mental health plans, managed care plans, and fee-for-service providers, Texas contracts with a single health plan for all foster children.

further review of children's clinical status and care. Further, Texas' health plan also includes a psychotropic medications utilization review process that allows it to identify and investigate physicians who consistently prescribe outside the state's utilization parameters.

Another state with a single public entity responsible for oversight is Illinois. By law, the Illinois Department of Children and Family Services (department) is responsible for consenting to the medical, surgical, and psychiatric care for children and adolescents in its custody. To meet these responsibilities related to the prescription of psychotropic medications, the department established a medication consent program. To support the consent process, the department contracted with a university to independently review all consent requests from clinicians to prescribe psychotropic medications to children in their care. Furthermore, Illinois includes in its Administrative Code—the equivalent of the California Code of Regulations—guidelines regarding the use of psychotropic medications for children in foster care. The Illinois guidelines contain similar clinical parameters to those in the *California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care* (state guidelines). However, while Illinois' guidelines are an appendix in its state regulations that specifically direct Illinois' child welfare department to oversee administration of psychotropic medications, California simply makes its guidelines available to counties for their use.

Foster Children's Health and Education Passports Contained Incomplete and Inaccurate Mental Health Data

We found that many Health and Education Passports did not include foster children's psychosocial services or authorized psychotropic medications.

Health and Education Passports are critical documents that summarize health and education information for foster children. Nonetheless, our review of 80 case files at the four counties we visited—Los Angeles, Madera, Riverside, and Sonoma—found that many children's Health and Education Passports were incomplete and inaccurate. For example, many of these Health and Education Passports did not include foster children's psychosocial services or authorized psychotropic medications. As a result, individuals and agencies involved with the foster children may be unaware of important components of their mental health histories. Absent such information, caregivers, health care providers, judicial officers, or county staff could make inappropriate or harmful health care decisions, such as prescribing new psychotropic medications that could interact harmfully with those a child is already receiving. Furthermore, inaccurate and incomplete data hamper the State's ability to ensure that foster children only receive medications that are safe and medically necessary.

Counties Often Did Not Adequately or Accurately Record Information About Foster Children's Psychotropic Medications in Social Services' Data System

State law requires that every foster child's case plan include a summary of his or her health and education information, as shown in the text box. According to state law, county staff must provide the summary to the foster child's caregivers within 30 days of placement and update the summary before each court date or within 48 hours of a change in placement. Although state law allows counties to maintain the summary in the form of a Health and Education Passport, it does not require it; however, the four counties we visited all use Health and Education Passports. According to Social Services, it designed the Health and Education Passport to meet the State's requirements. Social Services also stated that information in the Health and Education Passports is for use by caregivers, social workers, probation officers, the courts, medical professionals, and foster children.

Health and Education Passport Information

State law specifies the contents of a Health and Education Passport or summary required for each foster child. The relevant health information includes the following:

- Names and addresses for the child's health care providers, including mental health care providers.
- Immunizations and allergies.
- Known medical problems.
- Current medications.
- Past health problems and hospitalizations.
- Relevant mental health history.
- Known mental health conditions and medications.
- Any other relevant mental health information concerning the child determined to be appropriate by the director of the California Department of Social Services.

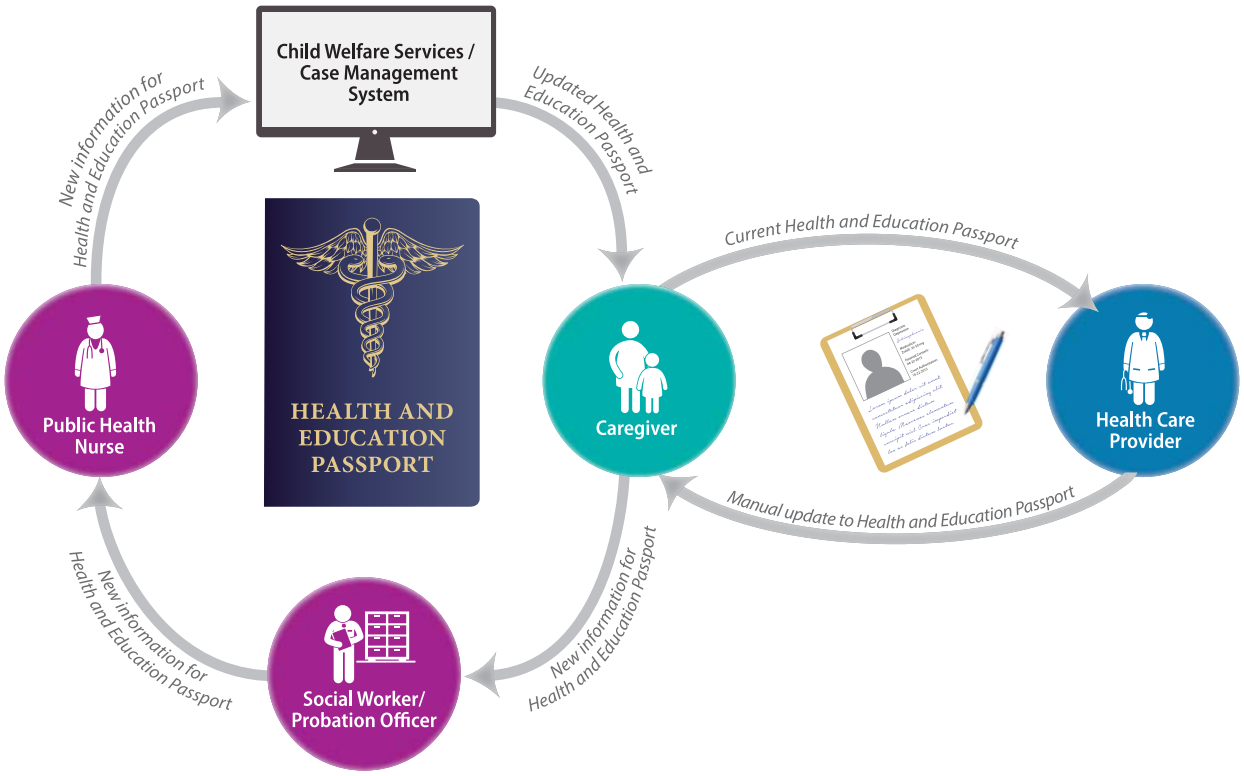
Source: *California Welfare and Institution Code, Section 16010(a).*

Social Services issued an information notice to all county welfare directors and chief probation officers in March 2008 that included specific requirements and instructions for properly entering the necessary information into its data system, which then populates the Health and Education Passports. Social Services also established a process for updating the Health and Education Passports, as Figure 4 on the following page shows. Specifically, each printed Health and Education Passport instructs a caregiver to bring it to all the foster child's health visits and to remind health care providers to add or correct information on it. It also instructs the caregiver to give the updated or corrected Health and Education Passport to the foster child's social worker or probation officer during his or her next visit. The social worker or probation officer should then forward the updated or corrected information to a public health nurse and then work with the public health nurse to enter the information into Social Services' data system.

Nonetheless, our review of the Health and Education Passports for 80 foster children at the four counties we visited found that the mental health information they contained—including psychotropic medications and psychosocial services—was frequently incomplete and inaccurate. Table 15 on page 57 summarizes the nature and extent of the concerns we identified. It shows that all 80 Health and Education Passports we reviewed were missing information about the corresponding psychosocial services the children should have received for at least one psychotropic medication, as we

describe in Chapter 1. Table 15 also shows that the Health and Education Passports for 13 (16 percent) of these foster children were missing at least one prescribed psychotropic medication that the courts or parents had authorized. Ten of these 13 Health and Education Passports were for foster children from two counties—Los Angeles and Sonoma. In fact, the Health and Education Passport for one of these foster children was missing three authorized psychotropic medications.

Figure 4
Flow of Information to Update the California Department of Social Services' Child Welfare Services/Case Management System and to Populate Health and Education Passports for Children in Foster Care



Sources: California State Auditor's review of the California Department of Social Services' Child Welfare Services/Case Management System training instructions, the Department of Health Care Services' Plan and Fiscal Guidelines for the Health Care Program for Children in Foster Care, and Health and Education Passports.

Note: The documents we examined do not specifically identify the persons who provide the Health and Education Passports to the caregivers.

In addition, 12 of the 80 Health and Education Passports were missing at least one prescription for a psychotropic medication that had been filled for the child but did not appear to have been authorized by the courts or parents. In these instances, the caregivers were apparently in possession of the prescribed psychotropic medications, but the counties never obtained court authorizations or parental consents. In fact, we identified

one instance in which a court denied a request to prescribe an antidepressant to a foster child, but the pharmacist filled the prescription for that medication shortly thereafter.

Table 15
Errors and Omissions in the Health and Education Passports for Children in Foster Care

	FOSTER CHILDREN'S HEALTH AND EDUCATION PASSPORTS...					
	...WERE MISSING...			...CONTAINED INACCURACIES SUCH AS...		
COUNTY	...CORRESPONDING PSYCHOSOCIAL SERVICES FOR AT LEAST ONE PSYCHOTROPIC MEDICATION	...AT LEAST ONE AUTHORIZED PRESCRIBED PSYCHOTROPIC MEDICATION	...AT LEAST ONE FILLED PRESCRIPTION FOR PSYCHOTROPIC MEDICATIONS THAT WERE NOT AUTHORIZED	...INCORRECT START DATES FOR AT LEAST ONE PSYCHOTROPIC MEDICATION	...INCORRECT COURT AUTHORIZATION DATES FOR AT LEAST ONE PSYCHOTROPIC MEDICATION*	...LESS RECENT INFORMATION THAN CONTAINED IN THE CHILD WELFARE SERVICES/CASE MANAGEMENT SYSTEM
Los Angeles	20/20	6/20	3/20	20/20	6/18	1/20
Madera	20/20	0/20	2/20	20/20	4/20	0/20
Riverside	20/20	3/20	3/20	20/20	2/20	0/20
Sonoma	20/20	4/20	4/20	20/20	7/9	6/20
Totals	**80/80**	**13/80**	**12/80**	**80/80**	**19/67**	**7/80**
	100%	**16%**	**15%**	**100%**	**28%**	**9%**

Sources: California State Auditor's analysis of selected foster care case files at each of the counties' welfare services departments and data obtained from the Department of Health Care Services' Paid Claims and Encounters System, the California Department of Social Services' Child Welfare Services/Case Management System, and matched Medi-Cal pharmacy data.

* Unless noted otherwise in the Table, we reviewed the case files for 20 foster children at each of the four counties, for a total of 80 foster children. For two counties, we reviewed fewer than 20 case files because the courts had delegated authority to administer psychotropic medications to some foster children's parents, and therefore, this column is not applicable for these children.

Besides missing certain information, all 80 Health and Education Passports we reviewed included inaccurate dates showing when the foster children started taking psychotropic medications, as shown in Table 15. In its 2008 information notice, Social Services instructed counties to enter into its data system the actual date that a foster child started taking a psychotropic medication. However, instead of entering this date, the four counties we visited entered the dates that prescribers saw children, the dates that court authorizations were filed, or the dates on which courts authorized prescriptions. Moreover, the Health and Education Passports for 19 (28 percent) of the 67 foster children for whom the court authorized psychotropic medications had inaccurate court authorization dates.

Table 15 also shows that seven foster children's Health and Education Passports were missing authorized psychotropic medications even though Social Services' data system included this information. Six of these seven children were from Sonoma County. For example, Social Services' data system showed that one foster child had two authorized psychotropic medications, both of which were antipsychotics; however, the child's Health and Education Passport did not reflect this information. We determined that although Sonoma County staff had entered information about the

six foster children's psychotropic medications into Social Services' data system, they did not follow Social Services' instructions to have the data system update the children's Health and Education Passports. In fact, in the above example, Sonoma County had not updated the foster child's Health and Education Passport in more than 10 years. In contrast, Riverside County, which had no such errors, provides written instructions to its staff on how to properly update Health and Education Passports after entering new medical information into Social Services' data system.

Finally, Social Services' data system includes a field for county staff to log the date when they provide the Health and Education Passports to caregivers. This field was blank in the records for 49 (61 percent) of the 80 foster children we examined. It is therefore unclear whether county staff actually provided the Health and Education Passports to these caregivers. We noted that Los Angeles and Riverside counties were responsible for 37 of the 49 case files with blank fields. Without these completed fields in Social Services' data system, the State lacks information to ensure that counties provided caregivers with critical information about foster children's health.

Selected Responsibilities of Foster Care Public Health Nurses

- Work with child welfare case workers to coordinate health care services, including psychosocial services.
- Serve as a liaison with health care professionals.
- Document that each child receives initial and follow-up health screenings that meet reasonable standards of medical practice.
- Collect health information and other relevant data on each foster child as available, including mental health services.
- Participate in medical care planning and coordinating for each foster child, which may include facilitating the acquisition of any necessary court authorizations for procedures or medications, as well as monitoring and providing oversight of psychotropic medications.
- Provide follow-up contact to assess each foster child's progress in meeting treatment goals.
- Assist nonminor dependents in making informed decisions about their health care, specifically helping them assume responsibility for their ongoing health care management while transitioning out of foster care.

Source: Welfare and Institutions Code, Section 16501.3.

Two General Factors Appear to Have Consistently Contributed to Foster Children's Incomplete Health and Education Passports

We determined that two general factors may have contributed to foster children's incomplete Health and Education Passports: the counties' insufficient number of public health nurses and a lack of information sharing among county departments. As described earlier, public health nurses work with social workers and probation officers to enter and update foster children's health and medical information in Social Services' data system. The public health nurses are part of the Health Care Program for Children in Foster Care (Health Program), a public health nursing program that is located in county child welfare services agencies and county probation departments. The Health Program provides public health nursing expertise in meeting the medical, dental, behavioral, and developmental health needs of children in out-of-home placements or foster care. State law identifies the public health nurses' responsibilities, as shown in the text box.

Social Services' inclusion of public health nurses and the Health Program in its state plan for 2015–2019 demonstrates the significance the State places on their role in overseeing psychotropic medications prescribed to foster children. In this federally required plan—which we describe in the Introduction—Social Services stated that public health nurses, in consultation and collaboration with others, are responsible for ensuring that every foster child has a current record of prescribed medications and for documenting medication information in the Health and Education Passports. Social Services also stated that the Health Program provides assurance that counties continue to identify and address foster children's physical and mental health needs.

Limited staff resources and the need to address foster children's serious medical conditions are asserted to be two reasons that constrain public health nurses' ability to maintain accurate and complete data in Social Services' data system.

However, the public health nurses at the four counties we visited indicated that limited staff resources and the need to address foster children's serious medical conditions constrain their ability to maintain accurate and complete data in Social Services' data system, which is then reflected in inaccurate and incomplete Health and Education Passports. For example, one public health nurse explained that she spent an estimated eight hours just to arrange an emergency root canal surgery for one foster child. She stated that foster children with threatening or serious medical conditions take precedence over basic medical data entries to update the Health and Education Passports.

The statements from the public health nurses are consistent with the ratio of public health nurses to foster children within each county. Documents issued by both Social Services and Health Care Services from around the time of the Health Program's original implementation in 2000 indicate that it intended to maintain an ideal ratio of one public health nurse per 200 foster children. However, Health Care Services' information from February 2016 showed that only 13 of California's 58 counties had public health nurse-to-foster-children ratios at or below 1-to-200. Further, the ratios for the four counties we visited ranged from 1-to-252 to 1-to-413.

Counties could improve these caseload ratios by funding additional public health nurses. Federal law states that the federal government will cover 75 percent of the costs for skilled professional medical personnel, such as public health nurses, as well as 75 percent of the cost for the medical personnel's necessary support staff. These support staff could enter information into the Health and Education Passports, freeing the public health nurses to oversee the support staff's work and to perform their other, more pressing responsibilities.

However, counties may not be obligated to implement Social Services' directives to address inaccurate and incomplete mental health information in Social Services' data system by taking actions such as hiring additional Health Program staff. As discussed in the

Introduction, realignment laws enacted in 2011 and 2012 moved program and fiscal responsibility for foster care to the counties, leaving Social Services with the role of providing oversight, training, and technical assistance to the counties. Around the same time, California voters enacted Proposition 30, which states that the counties are not obligated to implement new state laws, regulations, or administrative directives that increase local costs to administer child welfare services that were transferred to them as a result of the realignment laws, unless the State provides additional annual funding to pay for the increased costs. As a result, Social Services cannot simply issue directions and expect the counties to take steps to correct the data in its data system; instead, Social Services and the counties must reach agreement on a plan to improve the health information in Social Services' data system and on acceptable funding sources—likely from both the counties and the State—if that plan results in additional costs for the counties.

Although the counties appear to maintain records pertaining to foster children's psychosocial services, that information is split among separate county departments, which do not always share information with each other.

Another reason for incomplete Health and Education Passports is a lack of information sharing among the different county departments involved with foster children who receive psychosocial services, including psychotropic medications. Although the counties appear to maintain records pertaining to foster children's psychosocial services, that information is split among separate county departments, which do not always share information with each other. For instance, staff at two of the four counties we visited cited concerns over health information privacy laws as an impediment to the sharing of information about foster children's psychosocial services by county departments of mental health with county child welfare departments. In fact, according to the medical director of Sonoma County's Division of Behavioral Health, clearer guidance from the State as to what psychosocial services information can or cannot be shared is necessary; he stated that federal and state laws governing such information sharing are subject to interpretation and the California courts take very seriously the right to confidentiality and privacy of psychosocial services information.

However, according to a deputy director at Social Services and the chief medical information officer at Health Care Services, the federal Health Insurance Portability and Accountability Act (HIPAA), California's Confidentiality of Medical Information Act, and other state medical privacy laws do not prevent entities from sharing certain summary level information about foster children's psychosocial services for purposes of care coordination. Both the chief medical information officer at Health Care Services and the deputy director at Social Services stated that they would be amenable to issuing guidance to counties regarding the sharing of information to help ensure more complete Health and Education Passports.

As we mentioned in Chapter 1, the Judicial Council of California (Judicial Council) adopted new and revised forms—which became effective in July 2016—to be used in the court authorization process for foster children's psychotropic medications. The Judicial Council also revised its court rules to allow counties to develop their own processes to share information from the new forms with public health nurses. As a result, the use of the new forms may help the public health nurses obtain information on foster children's psychosocial services, which they or support staff can then include in Social Services' data system and in foster children's Health and Education Passports. Such changes could mitigate some of the problems that the lack of information sharing has likely caused in the past.

The State's and Counties' Lack of Reliable Data Has Impeded Their Oversight of Psychotropic Medications for Foster Children

Social Services' data system does not accurately record whether foster children have been prescribed psychotropic medications, how many medications were prescribed, or whether maximum daily dosages were within acceptable limits.

As discussed previously, Social Services' data system contains incomplete and inaccurate mental health information related to foster children. It does not accurately record whether foster children have been prescribed psychotropic medications, how many psychotropic medications they were prescribed, or whether maximum daily dosages were within acceptable limits. Further, using the data system, we were unable to determine whether foster children had follow-up visits with their prescribers or other health care providers within 30 days after starting new psychotropic medications and whether they received psychosocial services before or concurrent with their psychotropic medications. Finally, the data system does not accurately and consistently record whether counties obtained court or parental authorizations before foster children received psychotropic medications.

These incomplete and inaccurate data can hinder county and state oversight of psychotropic medications prescribed to foster children. Social workers, probation officers, caregivers, public health nurses, health care providers, and others at the county level use the health information in Social Services' data system and in the foster children's Health and Education Passports to assist in the provision of appropriate mental health care to foster children. If this health information is inaccurate or incomplete, these individuals could make decisions that are less than optimal or that could even result in harm to these children.

In addition to potentially hampering county-level coordination and oversight of foster children's mental health care, inaccurate and incomplete information in Social Services' data system may also impede the State's ability to oversee psychotropic medications prescribed to foster children. Social Services uses information from its data system for several purposes. For instance, it provides

data from its system to the California Child Welfare Indicators Project to allow policymakers, child welfare workers, researchers, and the public access to information on California's child welfare system.[13] However, users could draw inaccurate conclusions if they relied only on this information. For example, Measure 5F—which captures the number of foster children authorized for psychotropic medications recorded in Social Services' data system—does not accurately reflect the number of foster children with prescriptions for psychotropic medications because county staff have not entered all court or parental authorization information into the data system.

The State's ability to identify foster children who receive psychotropic medication prescriptions has improved since various state agencies and other government entities—including some counties—entered a data-sharing agreement in April 2015. Among other things, this data-sharing agreement between Health Care Services, Social Services, and other government entities allows them to share confidential data about foster children's psychosocial services and prescriptions. For example, Health Care Services used this agreement to share Medi-Cal pharmacy data about psychotropic medications with Social Services so Social Services could identify which foster children have prescriptions for psychotropic medications. Because this data-sharing agreement is still relatively new, Social Services and Health Care Services are still working to improve the links between their different data systems.

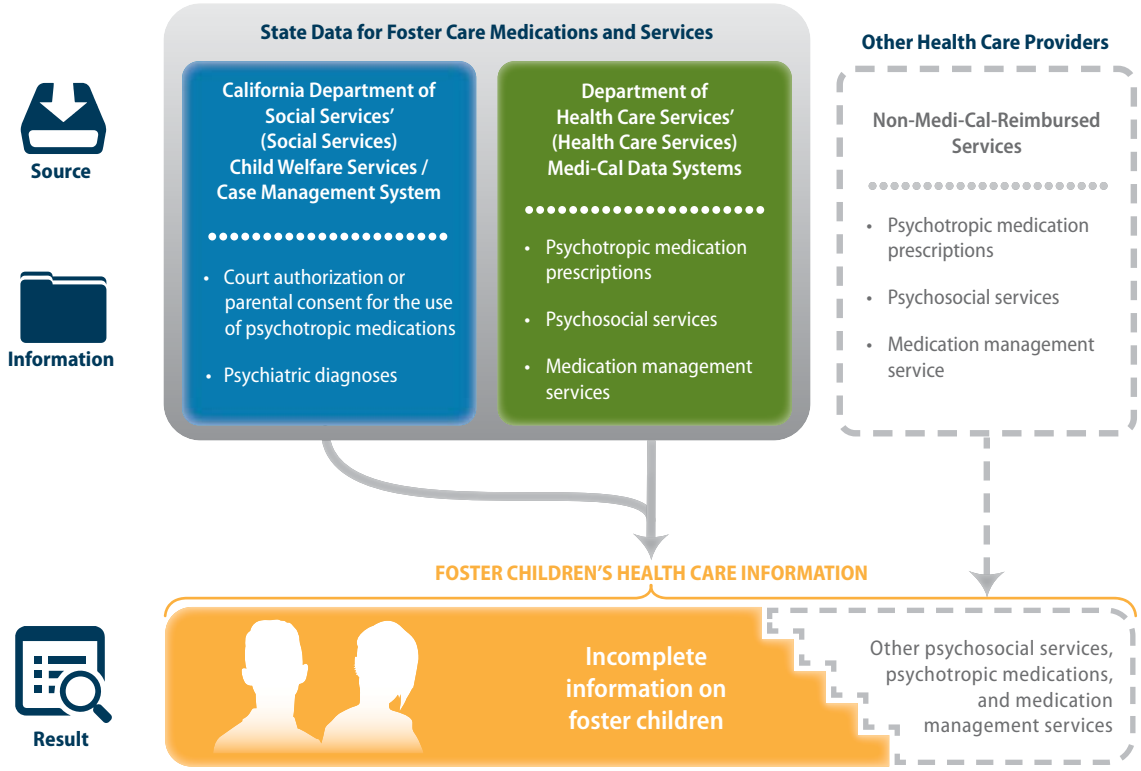
Health Care Services' data do not reflect psychosocial services or psychotropic medications for foster children for which Medi-Cal did not pay.

However, even with these improvements, county and state stakeholders are likely to continue to lack the accurate, complete information they need to make decisions or to analyze whether improvements occur over time. As discussed, Social Services' data are inaccurate and incomplete. However, Health Care Services' data also cannot paint a complete picture of foster children's psychosocial services and medications because, as shown in Figure 5, the data do not reflect those psychosocial services or psychotropic medications for which Medi-Cal did not pay and, as mentioned in Chapter 1, Health Care Services' procedure codes do not capture precisely the extent to which psychosocial services are provided to foster children. For example, a program manager at Sonoma County's Family, Youth and Children Division stated that the county paid for therapy services for three of the 20 foster children whose case files we reviewed; thus, Health Care Services' data did not reflect these services. Because neither Social Services nor Health Care Services has complete information on foster children's psychosocial services and psychotropic medications, combining their data will likely continue to result in an inaccurate summary. Consequently, state and county oversight of psychotropic medications administered to foster children

[13] The California Child Welfare Indicators Project is a collaborative venture between the University of California, Berkeley School of Social Work and Social Services that makes available child welfare administrative data to policymakers, child welfare workers, and the public on a website.

is likely to continue to be limited by weaknesses in the available data until Social Services successfully works with the counties to improve its data system.

Figure 5
Gaps in the State's Data Related to the Prescription of Psychotropic Medications to Children in Foster Care



Sources: California State Auditor's analysis of the Social Services' Child Welfare Services/Case Management System, Health Care Services' Medi-Cal data, and interviews with county officials.

Until Recently, the State's County-Level Reviews Included Only Minimal Examination of Psychotropic Medications Prescribed to Foster Children

As discussed in the Introduction, Social Services and Health Care Services took steps starting in 2012 to address the issue of psychotropic medications prescribed to foster children. However, the effectiveness of the practices that the two departments developed are largely dependent upon the counties' willingness to implement those practices—which many counties have not yet done. Further, neither Social Services nor Health Care Services included examinations of the prescription of psychotropic medications to foster children as part of their periodic reviews at the county level until recently. Consequently, the State has lacked assurance that the counties' monitoring of this issue adequately protects the best interests of foster children.

Quality Improvement Project Educational and Informational Materials

California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care: Released jointly by the California Department of Social Services and the Department of Health Care Services, the document describes best practices for the treatment of children in out-of-home care who may require psychotropic medications.

Questions to Ask About Medications: A document to help foster children, parents, and caregivers to improve their skills and knowledge about side effects and adverse symptoms related to medications.

Foster Youth Mental Health Bill of Rights: A document to educate foster children, parents, and caregivers about the rights of foster children as they pertain to psychotropic medications.

Sources: California Department of Social Services' All County Information Notice I-36-15—issued May 2015—and website.

In response to heightened national awareness regarding psychotropic medications prescribed to foster children, Social Services and Health Care Services established the Quality Improvement Project in 2012. Although it does not have official monitoring duties, the Quality Improvement Project has since produced educational and informational materials—as shown in the text box—to help assure the safe and appropriate prescribing and monitoring of psychotropic medications prescribed to foster children.

Additionally, the Quality Improvement Project devised ways in which the two departments and counties, under their data-sharing agreement, could use data results to aid in the oversight of psychotropic medications prescribed to foster children. For instance, since May 2015, Social Services has distributed to counties quarterly reconciliation reports that included case numbers of foster children who had paid Medi-Cal claims for psychotropic medications but no prior or concurrent authorizations recorded in Social Service's data system. Our review of these reports for the four counties we visited indicated that the counties used them to resolve possible discrepancies. For example, Los Angeles County's first reconciliation report identified 558 possible discrepancies. Its reconciliation report two quarters later listed only 240, a reduction of 318. Also, Social Services will provide more detailed case information, including foster children's names, identification numbers, medication names and dates, and placement types to those counties that sign on to the data-sharing agreement.

Although these and other practices we examined can help counties to ensure that providers properly prescribe psychotropic medications to foster children, the counties do not universally use them. For example, we found that counties did not always use the educational and informational materials the Quality Improvement Project produced. Furthermore, Social Services told us in May 2016 that only 19 of California's 58 counties—including Madera and Sonoma—had signed on to the data-sharing agreement. Consequently, the Quality Improvement Project's efforts to date have not resulted in widespread assurance that the State's and counties' collective oversight and monitoring mechanisms actually produce measureable, desirable results.

Until recently, the State's actual monitoring mechanisms for overseeing child welfare systems and the provision of health care services at the county level included only minimal examinations of psychotropic

medications prescribed to foster children. Social Services and Health Care Services conduct at least three different types of periodic reviews at the county level to examine different aspects of each county's child welfare system or health care and mental health service operations. We summarize these reviews in Table 16. Because the two departments have not included substantive examinations of the provision of psychotropic medications to foster children as part of these periodic reviews in the past, they missed opportunities to obtain critical information from more in-depth, county-by-county reviews of this issue. However, as of March 2016, Social Services and Health Care Services began collecting from the counties certain information about the provision of these medications.

Table 16
Types of County Reviews

REVIEW TYPE	ENTITIES PERFORMING THE REVIEW	ENTITIES REVIEWED	PURPOSE OF REVIEW	FREQUENCY OF REVIEW	CASE FILE REVIEW INCLUDED	PSYCHOTROPIC MEDICATIONS AND FOSTER CARE INCLUDED AS PART OF REVIEW	RESULTS OF REVIEW
California Child and Family Services Review	Collaboration between the California Department of Social Services (Social Services) and county child welfare departments and probation placement agencies.	County child welfare departments and probation placement agencies.	To strengthen the accountability system used in the State to monitor and assess the quality of services provided on behalf of maltreated children.	Ongoing. However, counties are to prepare and submit self-assessments and system improvement plans every five years and progress reports annually.	Yes, starting in 2015.	Yes, starting in 2008 and expanded in 2014.	County self-assessments, system improvement plans, and annual progress reports linked on Social Services' website.
Program Oversight and Compliance Review	Department of Health Care Services (Health Care Services).	County Medi-Cal mental health plans.	Verify that county Medi-Cal mental health plans provided medically necessary services in compliance with state regulations and the contract between Health Care Services and the plan.	Triennial.	Yes.	Yes, starting in fiscal year 2015–16.	County Medi-Cal mental health plans' submissions to Health Care Services of plans of correction for any items out of complance.
External Quality Reviews	Health Care Services, via contracts with private vendors.	County Medi-Cal managed care plans and county Medi-Cal mental health plans.	To evaluate the quality, access, and timeliness of health care services offered to Medi-Cal beneficiaries through Medi-Cal plans.	Annual.	No.	Not substantively.	Annual reports linked on Health Care Services' website.

Sources: Federal and state laws and regulations, documents obtained from Social Services and Health Care Services, and interviews with staff of Social Services.

One of the State's oversight mechanisms is Social Services' California Child and Family Services Review (California review). Social Services implemented the California review in 2004 in response to a state law requiring it to monitor county child welfare systems' performance, including foster care. According to Social Services, this review is an enhanced version of the federal Child and Family Services Review, through which the U.S. Department of Health and Human Services reviews each state's child welfare system to ensure that it provides quality services to children and families. The California review contains more measures than the federal review and has a primary focus on measuring each county child welfare system's performance in the areas of safety, permanence, and family well-being. The State's goal for the California review is to strengthen the accountability system it uses to monitor and assess the quality of services provided to maltreated children. According to Social Services, the review establishes core outcomes that are central to maintaining an effective system of child welfare services.

The California review is an ongoing, cyclical process that requires counties every five years to submit self-assessments in which they review their child welfare and probation office placement programs to determine the effectiveness of their current practices, programs, and resources. They must also submit system improvement plans every five years, which are operational agreements between the counties and Social Services that outline how counties plan to improve their system of care for children and families and address priority needs within the child welfare services system. Finally, the counties must prepare and submit annual progress reports to Social Services that provide a written analysis assessing whether their system improvement plans are achieving the desired results.

As part of the California review, the California Child Welfare Indicators Project publishes on its website data on all 58 counties' child welfare systems' performance related to specified outcome measures. Social Services also makes the data available on its website. With these measures, counties can identify areas in which they could improve performance. Currently, only one measure—Measure 5F—addresses the number of foster children authorized to receive psychotropic medications. As previously discussed, we found a number of weaknesses in the information this measure provides.

As of January 2014, Social Services expanded the county self-assessment reporting requirements to include a description and analysis of how the counties monitor the administration of prescription drugs, including psychotropic medications.

Further, until 2014, the county self-assessment component of Social Services' California reviews did not specifically address psychotropic medications prescribed to foster children other than what was required for Measure 5F. As of January 2014, Social Services expanded the self-assessment reporting requirements to include a description and analysis of how the counties monitor the appropriate administration of prescription medications, including psychotropic

medications for foster children. The most recent self-assessment reports for the four counties we visited are all dated before 2014, before implementation of the new requirement. Although the four counties have yet to fulfill this specific requirement, all have written procedures associated with the court's consideration of requests to authorize prescriptions of psychotropic medications to foster children.

In addition, Sonoma County was the only county of the four to address psychotropic medications as an area of needed improvement in its most recent system improvement plan for 2014 to 2019. In the plan, Sonoma noted that, with the exception of two counties with very small populations of foster children, it had the highest rate of foster children authorized for psychotropic medications: more than 24 percent in the fourth quarter of 2012, or nearly double the statewide rate at that time. Consequently, the plan stated that Sonoma's child welfare department would identify the causes of the high rate and develop monitoring processes to reduce by 5 percent the number of youth authorized for psychotropic medications. Although a subsequent annual progress report did not identify the causes for its high rate, it mentioned that Sonoma was implementing a number of steps to reduce the number of foster children prescribed psychotropic medications. These steps included engaging county partners in conversation about the problem, implementing an internal review process for court authorization requests for psychotropic prescriptions, and providing training on the issue for all its social workers.

Sonoma County was the only county of the four to address psychotropic medications as an area of needed improvement in its most recent system improvement plan for 2014 to 2019.

The State also monitors county mental health care plans (Medi-Cal mental health plans) through triennial program oversight and compliance reviews. Health Care Services conducts these triennial reviews, which verify that the Medi-Cal mental health plans provide medically necessary services to beneficiaries in compliance both with the terms of their contracts with Health Care Services and with state and federal laws and regulations. However, the review protocol for fiscal year 2014–15—which was essentially a checklist more than 90 pages long containing questions for which Health Care Services seeks answers—did not include any questions regarding psychotropic medications for foster children. Health Care Services recently took a step toward ensuring that its triennial reviews better address this issue in the future. Specifically, its review protocol for fiscal year 2015–16 includes three questions on the prescription of psychotropic medications to foster children.

A third state mechanism for monitoring counties' provision of health care is Health Care Services' annual external quality review (external review) of local Medi-Cal health plans. In accordance with federal law and regulations, Health Care Services must contract with third-party vendors to conduct external reviews that examine Medi-Cal beneficiaries' access to timely health care

services as well as the quality of their outcomes under county mental health care plans and county Medi-Cal managed care plans (Medi-Cal managed care plans). Health Care Services contracts with two organizations to conduct these external reviews and includes links to the organizations' reports on its website. However, the reports for the most recent annual external reviews for the Medi-Cal mental health plans and Medi-Cal managed care plans for the four counties we visited did not include substantive information regarding psychotropic medications prescribed to foster children.

Although external reviews annually examine the counties' Medi-Cal mental health plans and Medi-Cal managed care plans, the assistant chief of the Medical Review Branch within Health Care Services' Audits and Investigations Division indicated that the State has no similar oversight mechanism in place for health professionals who provide psychosocial services and then bill Medi-Cal via the fee-for-service approach. While more Medi-Cal beneficiaries are enrolling in managed care plans, foster children have the option to receive health care services from fee-for-service providers instead. Health Care Services is responsible for signing up and screening these providers. However, according to the assistant chief of the Medical Review Branch, the only oversight Health Care Services performs related to this type of provider involves identifying appropriate billing based on medical necessity criteria and federal and state reimbursement guidelines.

The three types of county-level reviews that Social Services and Health Care Services perform present an opportunity to gather first-hand information regarding the counties' administration of psychotropic medications to foster children.

The three types of county-level reviews that Social Services and Health Care Services perform present an opportunity for the departments to gather first-hand information regarding the counties' administration of psychotropic medications to foster children. These reviews could allow Social Services and Health Care Services to identify relevant deficiencies in this area and work with counties to resolve those deficiencies. Further, using the relevant results of these reviews in conjunction with complete and accurate state data, Social Services, Health Care Services, and their county partners could consider whether to modify their oversight structures to better ensure that providers only prescribe psychotropic medications to foster children when reasonably necessary.

The State Has Not Proactively Overseen Physicians Who Prescribe Psychotropic Medications for Foster Children

Although the State has mechanisms in place for reacting to complaints about physicians who may have inappropriately prescribed psychotropic medications to foster children, it does not currently take routine proactive steps to identify and correct inappropriate prescribing practices. The State oversees physicians through the Medical Board, which is responsible for issuing

physicians' licenses, investigating complaints, and imposing discipline. Its disciplinary actions may include administrative citations, fines, or license revocation. However, as of February 2016, its executive director stated that the Medical Board had not received any complaints against physicians for inappropriately prescribing psychotropic medications to foster children. Given the nature and extent of the issues we identified in Chapter 1 related to psychotropic medications, we believe that the lack of complaints to the Medical Board may suggest that this reactive approach alone is not sufficient to help ensure that physicians properly prescribe psychotropic medications to foster children.

Although the State also has other reactive methods through which it can monitor physicians who prescribe psychotropic medications to foster children, it is unclear whether these methods provide adequate oversight. For instance, state law requires Social Services to establish a foster care ombudsman's office to disseminate information on the rights of foster children and to investigate and attempt to resolve complaints made by or on behalf of foster children related to their care, placement, or services. Nonetheless, according to a consultant in the foster care ombudsman's office, a review of a sample of child welfare complaints over a four-year period showed that the office had not received complaints regarding children being overprescribed psychotropic medications. Similarly, state regulations allow Health Care Services to designate a Medi-Cal managed care ombudsman to investigate and resolve complaints between Medi-Cal beneficiaries and their managed care health plans. However, the chief of Health Care Services' Managed Care Operations Division told us that the managed care ombudsman's office does not investigate complaints regarding inappropriate prescribing of psychotropic medications to foster children and would refer any such complainants to another appropriate program.

Consequently, we believe that the State's reactive approach for overseeing physicians should be supplemented by more proactive steps to better ensure that physicians who prescribe psychotropic medications to foster children adhere to applicable guidelines. Although the Medical Board is trying to take proactive steps, its progress has been slow. Specifically, in April 2015 the Medical Board entered into an agreement with Health Care Services and Social Services to obtain pharmacy claims data for all foster children who were or had been on three or more psychotropic medications for 90 days or longer. The Medical Board's executive director stated that her staff had planned to analyze these data and investigate those physicians who exhibited inappropriate patterns of prescribing psychotropic medications to foster children. However, even though the Medical Board received these data in May 2015,

We believe the State's reactive approach for overseeing physicians should be supplemented by more proactive steps to better ensure that physicians who prescribe psychotropic medications to foster children adhere to applicable guidelines.

the executive director explained in February 2016 that the board had not yet been able to use it to identify physicians with potentially inappropriate prescribing habits.

The executive director attributed the delay to a number of causes. Specifically, she stated that the Medical Board was unable to contract with a consultant to analyze the data until November 2015 because it took longer than expected to identify an appropriate, available expert in the Sacramento area. She further stated that in late January 2016, the consultant reported to the Medical Board that the data were inadequate to perform the desired assessment. The consultant presented a list of additional information necessary to perform the desired analysis, such as each child's targeted diagnosis and weight, and each medication's dosage and frequency. In February 2016, the Medical Board met with Health Care Services and Social Services to request the additional information. Health Care Services responded in March 2016, stating that its claims system does not capture data for the targeted diagnoses, dosages, or frequency of the medications but that it could provide other data fields as substitutes. Health Care Services also said that Social Services could provide each child's weight to the extent its data system captured that information. The Medical Board requested these substitute data fields but, according to the executive director, was still waiting as of April 2016 to hear from the two departments.

Because the Medical Board has not yet received the necessary information from Health Care Services and Social Services, it does not know when it will be able to complete this project. However, its executive director asserted that if this project is successful in identifying physicians who may have inappropriately prescribed psychotropic medications to foster children, the Medical Board will continue working with Health Care Services and Social Services to review their data on a regular basis.

Off-label Use of Prescription Medications by Children

According to studies and other documents that we examined, physicians may prescribe medications for *off-label uses*, which are any uses that are not indicated on the medications' approved drug labels. Federal regulations state that any prescription medication approved by the U.S. Food and Drug Administration (FDA) must contain a drug label that identifies its approved uses, including the target population, diagnosis, dosages, and method of administration. According to the FDA, most medicines prescribed for children have not been tested in children and, by necessity, doctors have routinely prescribed medications for off-label use in children. However, the safety and effectiveness of a medication may or may not extend to all age groups or diagnoses that were not tested, which could pose additional risks to a patient prescribed a medication for off-label purposes. Nevertheless, according to the American Academy of Child and Adolescent Psychiatry, it is ethical, appropriate, and consistent with general medical practice to prescribe medication off-label when clinically indicated.

Sources: California State Auditor's review of the FDA's regulations and website and of studies and other documents related to off-label use of medications.

Health Care Services Does Not Ensure That Pharmacists Obtain Its Approval Before They Dispense Psychotropic Medications to Foster Children for Off-Label Uses

Health Care Services has not consistently ensured that pharmacists obtain its approval before they dispense psychotropic medications to foster children for purposes other than those indicated on the medications' product labels. As the text box describes, such uses of prescription medications

are considered off-label because they do not have the approval of the U.S. Food and Drug Administration (FDA). State regulations require pharmacists to obtain approved treatment authorization requests (TARs) before dispensing any medication, including psychotropic medications, to be used for off-label purposes, except in cases of emergency. According to an American Bar Association 2011 Practice and Policy Brief, more than 75 percent of psychotropic medication use by children and adolescents is likely prescribed for off-label purposes. However, our review found that few pharmacists had obtained TARs when dispensing these medications to foster children.

Health Care Services' staff pharmacists review and adjudicate TARs, either approving the requests, denying them, or deferring them in order to gather more information from the health care providers—including the prescribing physicians—before making decisions. According to the chief of its Clinical Assurance and Administrative Support Division, Health Care Services' staff pharmacists look at the type of medication and the child's diagnosis, and then evaluate the following questions as part of each TAR review:

- Whether the intended use is FDA-approved.
- Whether the usage is age-appropriate.
- Whether the regular and daily dosage amounts are appropriate for a child's age and size.
- Whether the medication is medically necessary.
- Whether the medication is in the same pharmaceutical class as any other medications the child is receiving.
- In the case of antipsychotic medications, whether the child is receiving metabolic monitoring as part of monitoring side effects.

State regulations allow Health Care Services to authorize the off-label use of medications when that use represents a reasonable and current prescribing practice.

State regulations allow Health Care Services to authorize the off-label use of medications when that use represents reasonable and current prescribing practice. For example, our review of the case files for 80 foster children at the four counties we visited showed that a number of physicians prescribed trazodone—an antidepressant—to treat insomnia. Although this usage is not indicated on the medication's FDA-approved label, a 2010 survey of the members of the American Academy of Child and Adolescent Psychiatry found that trazodone was the most commonly prescribed insomnia medication for children with anxiety disorders.[14] The results of this survey suggest that prescribing trazodone for insomnia is a reasonable off-label use.

[14] The FDA-approved label for trazodone lists somnolence, or sleepiness, as an adverse reaction.

Pharmacists failed to submit TARs, as state regulations require, in nearly all instances of off-label use we reviewed.

Although the TARs review process provides an opportunity for the State to ensure that foster children only receive psychotropic medications for appropriate off-label purposes, our review found that pharmacists rarely obtained approved TARs before dispensing these medications. Specifically, when we reviewed the case files for the 80 foster children, we identified 45 children to whom physicians prescribed at least one psychotropic medication for an off-label use. However, when we asked Health Care Services to provide approved TARs for the medications prescribed for these 45 foster children, it could not do so for 44 of them—even though some of the children were receiving multiple psychotropic medications for off-label purposes. In other words, pharmacists failed to submit TARs, as state regulations require, in nearly all instances of off-label use.

When it does not receive, review, and approve TARs for psychotropic medications prescribed for off-label use by foster children, Health Care Services has less assurance that physicians have properly prescribed these medications. For example, in April 2014 a physician prescribed Seroquel—an antipsychotic medication that the FDA approved to treat symptoms of bipolar disorder in patients 10 and older or schizophrenia in patients 13 and older—to a 15-year-old foster child. However, the physician prescribed Seroquel to treat "mood dysregulation" with symptoms of moodiness, irritability, anger problems, and arguing. Although we concluded that this was an off-label use because the documents did not mention bipolar disorder or schizophrenia, Health Care Services could not provide an approved TAR.

Pharmacists rarely submitted TARs for off-label prescriptions in part because Health Care Services has not programmed its claims system to identify medications prescribed for off-label use in order to prompt pharmacists to submit TARs. According to a section chief in its Clinical Assurance and Administrative Services Division (section chief), Health Care Services relies on pharmacists to voluntarily identify when medications are prescribed for off-label uses. However, the section chief acknowledged that few dispensing pharmacists devote the time or have the information necessary to determine whether psychotropic medications are prescribed for off-label purposes.

The chief of Health Care Services' Pharmacy Benefits Division (chief of pharmacy benefits) indicated that Health Care Services has not programmed its claims system to identify off-label prescriptions of psychotropic medications using children's diagnoses because prescriptions do not always include reliable diagnoses that indicate the purposes of the medications. Without a diagnosis, the system cannot determine whether a medication is being prescribed for an off-label purpose. The chief of pharmacy benefits also stated that for Health Care Services to use diagnoses to enforce the TAR requirement for off-label purposes through its claims system,

it would need to require TARs for all psychotropic medication prescriptions, which would result in the submission of unnecessary TARs and impede foster children's access to medications they need.

Health Care Services' claims system could better oversee the appropriateness of off-label use for psychotropic medications by creating a TAR process based on children's ages.

However, even if Health Care Services cannot reasonably program its claims system to detect prescriptions for off-label uses based on diagnoses, the claims system could still trigger a TAR requirement for off-label use for psychotropic medications based on children's ages, just as it currently does for antipsychotic medications. Specifically, for service dates on or after October 1, 2014, Health Care Services began requiring TARs for antipsychotic medications prescribed to Medi-Cal beneficiaries under age 18, including foster children. According to the chief of pharmacy benefits, Health Care Services enacted this TAR requirement to ensure the safe and appropriate use of these medications by children given their severe and potentially irreversible side effects. Health Care Services enforces this TAR requirement by having its claims system automatically prompt pharmacists to submit TARs whenever they submit claims for antipsychotic medications prescribed to Medi-Cal beneficiaries under 18 years old. Health Care Services appears to properly enforce this TAR requirement; it provided approved TARs for the 27 foster children we reviewed who had prescriptions for antipsychotic medications filled after October 1, 2014.

The section chief noted that since implementing the TAR requirement in October 2014, Health Care Services has denied some TARs for antipsychotics that it deemed were medically inappropriate for various reasons, including for too-high dosages, concurrent use of multiple psychotropic medications, and off-label uses that were not medically justified. In fact, in April 2015 Health Care Services denied a TAR for the foster child we mentioned previously who had been prescribed Seroquel—an antipsychotic medication—for an off-label use. According to the section chief, the claims system required the TAR because of the patient's age, which allowed Health Care Services to request additional information—including the child's specific diagnosis, the clinical justification for the medication, and evidence of metabolic monitoring—to assess the medication's appropriateness. According to the section chief, the pharmacist did not provide the requested information within 30 business days, so Health Care Services automatically denied the TAR.

Although Health Care Services may not be able to ensure that it reviews all off-label uses of psychotropic medications by foster children, we believe it can better oversee the appropriateness of some of these medications by creating a TAR process similar to the one it uses to for antipsychotic medications but focused specifically on children's ages. Of the 45 psychotropic medications we identified from the case files we reviewed, 19—or 42 percent—were not FDA-approved for any use by patients under age 18 as of March 2016.

The chief of pharmacy benefits agreed that Health Care Services should consider programming its claims system to trigger TAR requirements for these psychotropic medications based on the patients' ages. He also stated that Health Care Services should evaluate alternative tools and procedures to identify off-label use of medications and better enforce compliance with TAR requirements. For example, he stated Health Care Services could consider developing a process through which its Audits and Investigations Division could include off-label TARs in its retail pharmacy audits.

Finally, as discussed earlier, the Judicial Council recently adopted new and revised forms to request court authorization of psychotropic medications prescribed to foster children. These forms now require physicians to describe why they prescribed psychotropic medications not approved for a child this age. County staff can use this information to better ensure that foster children were properly prescribed psychotropic medications.

Recommendations

Legislature

To improve the State's and counties' oversight of psychotropic medications prescribed to foster children, the Legislature should require Social Services to collaborate with its county partners and other relevant stakeholders to develop and implement a reasonable oversight structure that addresses, at a minimum, the concerns identified in this audit report.

To improve the State's oversight of physicians who prescribe psychotropic medications to foster children, the Legislature should require the Medical Board to analyze Health Care Services' and Social Services data in order to identify physicians who may have inappropriately prescribed psychotropic medications to foster children. If this initial analysis successfully identifies such physicians, the Legislature should require the Medical Board to periodically perform the same or similar analyses in the future. Further, the Legislature should require Health Care Services and Social Services to provide periodically to the Medical Board the data necessary to perform these analyses.

California Department of Social Services

To improve the oversight of psychotropic medications prescribed to foster children, Social Services should collaborate with the counties and other relevant stakeholders—including Health Care Services, as

necessary—to develop and implement a reasonable oversight structure that ensures the coordination of the State's and counties' various oversight mechanisms as well as the accuracy and completeness of the information in Social Services' data system. This structure should include at least the following items:

- Identification of the specific oversight responsibilities to be performed by the various state and local government agencies.
- An agreement on how county staff such as social workers, probation officers, and public health nurses will use printed Health and Education Passports to obtain foster children's necessary mental health information—including psychotropic medications and psychosocial services—for inclusion in Social Services' data system.
- A plan to ensure that counties have sufficient staff available to enter foster children's mental health information into Social Services' data system and the resources to pay for those staff.
- An agreement on the specific information related to psychotropic medication—including but not limited to the medication name, maximum daily dosage, and court authorization date—and psychosocial services and medication follow-up appointment information that county staff must enter into Social Services' data system for inclusion in foster children's Health and Education Passports.
- Specific directions from Social Services regarding the correct medication start dates and court authorization dates counties should include in its data system and foster children's Health and Education Passports.
- An agreement on the training or guidance Social Services should provide to county staff members working with Social Services' data system to ensure that they know how to completely and accurately update foster children's Health and Education Passports.
- An agreement on how the counties will use information on the new authorization forms that the Judicial Council approved to better oversee the prescription of psychotropic medications to foster children.
- An agreement regarding how counties will implement, use, or disseminate the educational and informational materials the Quality Improvement Project has produced, including the *California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care, Questions to Ask About Medications*, and the *Foster Youth Mental Health Bill of Rights*.

- An agreement on the specific measures and the best available sources of data the State and counties will use to oversee foster children prescribed psychotropic medications, including psychosocial services and medication follow-up appointments.

- An agreement on how the State and counties will oversee psychotropic medications prescribed to foster children by fee-for-service providers who are not affiliated with county Medi-Cal mental health plans.

- An agreement on the extent of information related to psychotropic medications prescribed to foster children that counties will include in the self-assessments, system improvement plans, and annual progress reports they develop as part of Social Services' California Child and Family Services Reviews.

- An agreement on the extent of the information related to psychotropic medications prescribed to foster children that counties will include in their responses to Health Care Services' reviews, including its county Medi-Cal mental health plan compliance reviews and external quality reviews.

California Department of Social Services and the Department of Health Care Services

To ensure that the Medical Board can promptly complete its analysis to identify physicians who may have inappropriately prescribed psychotropic medications to foster children, Social Services and Health Care Services should continue to work with the Medical Board and its consultant to meet their data needs. If the Medical Board's analysis is able to identify these physicians, Social Services and Health Care Services should enter into an agreement with the Medical Board to provide the information the Medical Board needs to perform similar analyses in the future.

Department of Health Care Services

To increase the State's assurance that foster children do not receive medically inappropriate or unnecessary psychotropic medications, Health Care Services should devise and implement within six months methods to better enforce its prior authorization requirement for the off-label use of psychotropic medications. For example, Health Care Services should revise its claims system to automatically prompt pharmacists to submit treatment authorization requests when filling prescriptions for Medi-Cal beneficiaries under age 18 when the prescribed psychotropic medications have no FDA-approved pediatric uses. Furthermore,

as part of its collaboration with Social Services and the counties to develop and implement a reasonable oversight structure, Health Care Services should determine whether information from the Judicial Council's revised court authorization forms would help it better enforce its prior authorization requirements.

Medical Board of California

To ensure that physicians do not inappropriately prescribe psychotropic medications to foster children, the Medical Board should take the following steps:

- Within 60 days, obtain and analyze the data from Health Care Services and Social Services to identify physicians who may have inappropriately prescribed psychotropic medications for foster children.

- Following the completion of this analysis, take the appropriate follow-up actions that it deems necessary, including the investigation of physicians identified in its analysis.

- To the extent that its analysis is able to identify physicians who may have inappropriately prescribed psychotropic medications to foster children, the Medical Board should enter into an agreement with Health Care Services and Social Services within six months of completing its initial review to periodically obtain the data necessary to perform the same or similar analyses.

We conducted this audit under the authority vested in the California State Auditor by Section 8543 et seq. of the California Government Code and according to generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives specified in the Scope and Methodology section of the report. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Respectfully submitted,

Elaine M. Howle

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Appendix

SUMMARY TABLES SHOWING STATEWIDE AND COUNTY DATA REGARDING PSYCHOTROPIC MEDICATIONS PRESCRIBED TO FOSTER CHILDREN

As part of our review of psychotropic medications prescribed to children in foster care (foster children), we analyzed data obtained from the California Department of Social Services' (Social Services) Child Welfare Services/Case Management System and Medi-Cal pharmacy data from the Department of Health Care Services (Health Care Services). We present the results of our analysis that pertain to the four counties we visited in Chapter 1 and Chapter 2. The following tables summarize the results of our analysis for the State as a whole and for each of California's 58 counties. To protect individual privacy, we omitted results of 10 foster children or fewer.

Table A-1, beginning on the following page, shows the number of foster children in California and the number and proportion of those foster children with filled prescriptions for psychotropic medications for three fiscal years. As this Table shows, the number of foster children in California increased from fiscal year 2012–13 through 2014–15, while the number of foster children with filled prescriptions for psychotropic medications decreased over the same time period. Data for the counties included in the Table showed varying trends.

Table A-1

Number and Proportion of Children in Foster Care With Filled Psychotropic Medication Prescriptions During Fiscal Years 2012–13 Through 2014–15, Statewide and by County

	FOSTER CHILDREN						FOSTER CHILDREN WITH FILLED PRESCRIPTIONS FOR PSYCHOTROPIC MEDICATIONS					
	FISCAL YEAR 2012–13		FISCAL YEAR 2013–14		FISCAL YEAR 2014–15		FISCAL YEAR 2012–13		FISCAL YEAR 2013–14		FISCAL YEAR 2014–15	
	NUMBER	PERCENT OF FOSTER CHILDREN STATEWIDE	NUMBER	PERCENT OF FOSTER CHILDREN STATEWIDE	NUMBER	PERCENT OF FOSTER CHILDREN STATEWIDE	NUMBER	PERCENT OF FOSTER CHILDREN IN THE STATE/COUNTY	NUMBER	PERCENT OF FOSTER CHILDREN IN THE STATE/COUNTY	NUMBER	PERCENT OF FOSTER CHILDREN IN THE STATE/COUNTY
Statewide	77,043	100.0%	78,859	100.0%	79,166	100.0%	10,048	13.0%	9,707	12.3%	9,317	11.8%
Counties												
Alameda	2,048	2.7%	2,001	2.5%	1,939	2.4%	384	18.8%	323	16.1%	298	15.4%
Amador	64	0.1	75	0.1	90	0.1	12	18.8	12	16.0	17	18.9
Butte	647	0.8	610	0.8	643	0.8	111	17.2	85	13.9	76	11.8
Calaveras	140	0.2	205	0.3	190	0.2	*	*	22	10.7	26	13.7
Contra Costa	1,435	1.9	1,450	1.8	1,454	1.8	236	16.4	221	15.2	215	14.8
Del Norte	136	0.2	144	0.2	137	0.2	18	13.2	16	11.1	14	10.2
El Dorado	428	0.6	418	0.5	398	0.5	59	13.8	64	15.3	69	17.3
Fresno	2,258	2.9	2,408	3.1	2,534	3.2	225	10.0	234	9.7	246	9.7
Glenn	88	0.1	119	0.2	95	0.1	11	12.5	17	14.3	12	12.6
Humboldt	330	0.4	366	0.5	444	0.6	43	13.0	38	10.4	43	9.7
Imperial	403	0.5	452	0.6	517	0.7	50	12.4	68	15.0	75	14.5
Kern	2,185	2.8	2,105	2.7	2,190	2.8	251	11.5	253	12.0	249	11.4
Kings	582	0.8	611	0.8	761	1.0	51	8.8	46	7.5	51	6.7
Lake	165	0.2	164	0.2	186	0.2	32	19.4	34	20.7	33	17.7
Lassen	111	0.1	129	0.2	113	0.1	*	*	18	14.0	17	15.0
Los Angeles	27,100	35.2	27,577	35.0	27,466	34.7	3,487	12.9	3,267	11.8	3,194	11.6
Madera	393	0.5	443	0.6	427	0.5	24	6.1	23	5.2	21	4.9
Marin	150	0.2	137	0.2	142	0.2	18	12.0	14	10.2	20	14.1
Mariposa	43	0.1	33	0.0	14	0.0	11	25.6	*	*	*	*
Mendocino	327	0.4	354	0.4	343	0.4	52	15.9	55	15.5	48	14.0
Merced	845	1.1	883	1.1	788	1.0	90	10.7	85	9.6	81	10.3
Monterey	495	0.6	520	0.7	573	0.7	107	21.6	116	22.3	94	16.4
Napa	181	0.2	196	0.2	208	0.3	34	18.8	36	18.4	30	14.4
Nevada	145	0.2	129	0.2	118	0.1	30	20.7	16	12.4	18	15.3

continued on next page . . .

	FOSTER CHILDREN						FOSTER CHILDREN WITH FILLED PRESCRIPTIONS FOR PSYCHOTROPIC MEDICATIONS					
	FISCAL YEAR 2012–13		FISCAL YEAR 2013–14		FISCAL YEAR 2014–15		FISCAL YEAR 2012–13		FISCAL YEAR 2013–14		FISCAL YEAR 2014–15	
	NUMBER	PERCENT OF FOSTER CHILDREN STATEWIDE	NUMBER	PERCENT OF FOSTER CHILDREN STATEWIDE	NUMBER	PERCENT OF FOSTER CHILDREN STATEWIDE	NUMBER	PERCENT OF FOSTER CHILDREN IN THE STATE/COUNTY	NUMBER	PERCENT OF FOSTER CHILDREN IN THE STATE/COUNTY	NUMBER	PERCENT OF FOSTER CHILDREN IN THE STATE/COUNTY
Orange	3,126	4.1%	3,024	3.8%	2,923	3.7%	322	10.3%	301	10.0%	257	8.8%
Placer	406	0.5	445	0.6	424	0.5	51	12.6	57	12.8	56	13.2
Plumas	91	0.1	71	0.1	79	0.1	*	*	*	*	12	15.2
Riverside	5,673	7.4	6,093	7.7	6,191	7.8	558	9.8	600	9.8	595	9.6
Sacramento	3,062	4.0	3,394	4.3	3,436	4.3	442	14.4	456	13.4	424	12.3
San Bernardino	5,457	7.1	5,789	7.3	6,378	8.1	695	12.7	680	11.7	660	10.3
San Diego	4,662	6.1	4,412	5.6	4,239	5.4	590	12.7	548	12.4	475	11.2
San Francisco	1,256	1.6	1,180	1.5	1,088	1.4	203	16.2	183	15.5	150	13.8
San Joaquin	1,641	2.1	1,834	2.3	1,820	2.3	253	15.4	269	14.7	248	13.6
San Luis Obispo	549	0.7	492	0.6	460	0.6	92	16.8	86	17.5	79	17.2
San Mateo	437	0.6	387	0.5	386	0.5	66	15.1	66	17.1	69	17.9
Santa Barbara	776	1.0	749	0.9	672	0.8	111	14.3	102	13.6	103	15.3
Santa Clara	1,628	2.1	1,685	2.1	1,689	2.1	205	12.6	205	12.2	213	12.6
Santa Cruz	419	0.5	407	0.5	377	0.5	47	11.2	56	13.8	43	11.4
Shasta	765	1.0	769	1.0	708	0.9	100	13.1	113	14.7	96	13.6
Siskiyou	175	0.2	173	0.2	157	0.2	32	18.3	27	15.6	20	12.7
Solano	516	0.7	515	0.7	564	0.7	84	16.3	86	16.7	85	15.1
Sonoma	733	1.0	680	0.9	616	0.8	173	23.6	142	20.9	140	22.7
Stanislaus	919	1.2	958	1.2	875	1.1	120	13.1	116	12.1	117	13.4
Sutter	188	0.2	172	0.2	182	0.2	35	18.6	40	23.3	36	19.8
Tehama	259	0.3	280	0.4	311	0.4	37	14.3	41	14.6	33	10.6
Tulare	1,221	1.6	1,363	1.7	1,435	1.8	169	13.8	166	12.2	165	11.5
Tuolumne	145	0.2	157	0.2	170	0.2	16	11.0	*	*	16	9.4
Ventura	1,198	1.6	1,243	1.6	1,213	1.5	185	15.4	167	13.4	153	12.6
Yolo	334	0.4	372	0.5	377	0.5	45	13.5	41	11.0	43	11.4
Yuba	196	0.3	224	0.3	275	0.3	27	13.8	36	16.1	40	14.5
Other counties*	512	0.7	462	0.6	351	0.4	29	5.7	30	6.5	*	*

Sources: California State Auditor's analysis of data obtained from the California Department of Social Services' Child Welfare Services/Case Management System and matched Medi-Cal pharmacy data.

Note: The term *foster children* refers to children aged zero to 17 in the foster care system.

* To protect individual privacy, we omitted this number because it would identify 10 or fewer foster children. Such omission is in accordance with aggregate data reporting guidelines issued by the Department of Health Care Services.

Table A-2 lists the number and proportion of filled psychotropic medication prescriptions for foster children for three fiscal years. This Table shows that the number of psychotropic medication prescriptions statewide dropped from more than 110,000 in fiscal year 2012–13 to about 95,750 in fiscal year 2014–15, a decrease of 13 percent. Similarly, all but 12 counties had a decrease in their number of psychotropic medication prescriptions from fiscal year 2012–13 through 2014–15.

Table A-2
Number and Proportion of Filled Psychotropic Medication Prescriptions for Children in Foster Care, Statewide and by County

	FISCAL YEAR 2012–13		FISCAL YEAR 2013–14		FISCAL YEAR 2014–15	
	NUMBER	PERCENT OF PRESCRIPTIONS	NUMBER	PERCENT OF PRESCRIPTIONS	NUMBER	PERCENT OF PRESCRIPTIONS
Statewide	110,014	100.0%	106,510	100.0%	95,748	100.0%
Counties						
Alameda	3,751	3.4%	3,469	3.3%	3,097	3.2%
Alpine	0	NA	0	NA	0	NA
Amador	211	0.2	226	0.2	214	0.2
Butte	1,244	1.1	1,058	1.0	1,139	1.2
Calaveras	79	0.1	226	0.2	358	0.4
Colusa	55	0.0	50	0.0	68	0.1
Contra Costa	3,091	2.8	2,918	2.7	2,585	2.7
Del Norte	236	0.2	184	0.2	217	0.2
El Dorado	771	0.7	853	0.8	702	0.7
Fresno	2,443	2.2	2,566	2.4	2,582	2.7
Glenn	136	0.1	162	0.2	84	0.1
Humboldt	465	0.4	512	0.5	414	0.4
Imperial	362	0.3	488	0.5	576	0.6
Inyo	61	0.1	11	0.0	0	NA
Kern	3,373	3.1	3,105	2.9	2,804	2.9
Kings	552	0.5	533	0.5	606	0.6
Lake	462	0.4	464	0.4	424	0.4
Lassen	117	0.1	185	0.2	212	0.2
Los Angeles	33,825	30.7	31,208	29.3	29,894	31.2
Madera	231	0.2	275	0.3	158	0.2
Marin	189	0.2	150	0.1	146	0.2
Mariposa	108	0.1	60	0.1	34	0.0
Mendocino	724	0.7	690	0.6	426	0.4
Merced	1,336	1.2	1,220	1.1	850	0.9
Modoc	17	0.0	44	0.0	53	0.1
Mono	30	0.0	21	0.0	*	*
Monterey	1,156	1.1	1,286	1.2	1,067	1.1
Napa	451	0.4	415	0.4	265	0.3
Nevada	365	0.3	181	0.2	212	0.2

	FISCAL YEAR 2012–13		FISCAL YEAR 2013–14		FISCAL YEAR 2014–15	
	NUMBER	PERCENT OF PRESCRIPTIONS	NUMBER	PERCENT OF PRESCRIPTIONS	NUMBER	PERCENT OF PRESCRIPTIONS
Orange	3,576	3.3%	3,368	3.2%	2,795	2.9%
Placer	454	0.4	585	0.5	603	0.6
Plumas	67	0.1	79	0.1	95	0.1
Riverside	6,214	5.6	6,753	6.3	6,024	6.3
Sacramento	4,804	4.4	5,241	4.9	4,391	4.6
San Benito	37	0.0	69	0.1	105	0.1
San Bernardino	8,291	7.5	7,979	7.5	7,192	7.5
San Diego	7,122	6.5	6,718	6.3	4,898	5.1
San Francisco	2,071	1.9	2,076	1.9	1,749	1.8
San Joaquin	3,115	2.8	3,183	3.0	2,919	3.0
San Luis Obispo	1,098	1.0	966	0.9	977	1.0
San Mateo	759	0.7	746	0.7	607	0.6
Santa Barbara	1,424	1.3	1,248	1.2	1,185	1.2
Santa Clara	2,608	2.4	2,410	2.3	2,165	2.3
Santa Cruz	490	0.4	428	0.4	354	0.4
Shasta	1,183	1.1	1,187	1.1	760	0.8
Sierra	11	0.0	0	NA	*	*
Siskiyou	380	0.3	365	0.3	303	0.3
Solano	837	0.8	905	0.8	792	0.8
Sonoma	2,126	1.9	1,809	1.7	1,479	1.5
Stanislaus	1,215	1.1	1,072	1.0	1,138	1.2
Sutter	556	0.5	643	0.6	508	0.5
Tehama	306	0.3	432	0.4	266	0.3
Trinity	79	0.1	25	0.0	72	0.1
Tulare	2,109	1.9	2,212	2.1	1,913	2.0
Tuolumne	189	0.2	119	0.1	164	0.2
Ventura	2,133	1.9	2,298	2.2	2,057	2.1
Yolo	486	0.4	455	0.4	422	0.4
Yuba	432	0.4	579	0.5	613	0.6

Sources: California State Auditor's analysis of data obtained from the California Department of Social Services' Child Welfare Services/Case Management System and matched Medi-Cal pharmacy data.

Notes: The term *foster children* refers to children aged zero to 17 in the foster care system.

The average number of filled prescriptions per foster child may reflect that some foster children received more than one type of psychotropic medication. Alternatively, it may indicate that some foster children had paid prescriptions of a single medication filled a number of times during the year (perhaps on a monthly or bimonthly basis).

NA = Not applicable.

* To protect individual privacy, we omitted this number because it would identify 10 or fewer foster children. Such omission is in accordance with aggregate data reporting guidelines issued by the Department of Health Care Services.

For Table A-3 beginning on the following page, we separated the number and proportion of prescriptions for psychotropic medications into five different categories for fiscal year 2014–15. This Table shows that antidepressants and antipsychotics each made up 35 percent or more of all psychotropic medication prescriptions, and stimulants made up 26 percent. The last two classifications—antianxiety medications and mood stabilizers—were a very small proportion of the total psychotropic medication prescriptions, with each representing 2 percent or less. In many instances, county-level data mirrored the State's results.

Table A-3

Number and Proportion of Filled Prescriptions for Psychotropic Medications for Children in Foster Care in Fiscal Year 2014–15 by Classification, Statewide and by County

	TOTAL NUMBER OF FILLED PRESCRIPTIONS FOR PSYCHOTROPIC MEDICATIONS	ANTIANXIETY MEDICATIONS		ANTIDEPRESSANTS		ANTIPSYCHOTICS		MOOD STABILIZERS		STIMULANTS	
		NUMBER	PERCENT OF PRESCRIPTIONS	NUMBER	PERCENT OF PRESCRIPTIONS	NUMBER	PERCENT OF PRESCRIPTIONS	NUMBER	PERCENT OF PRESCRIPTIONS	NUMBER	PERCENT OF PRESCRIPTIONS
Statewide	95,748	852	0.9%	34,586	36.1%	33,303	34.8%	1,898	2.0%	25,109	26.2%
Counties											
Alameda	3,097	22	0.7%	1,229	39.7%	1,154	37.3%	81	2.6%	611	19.7%
Alpine	0	0	NA	0	NA	0	NA	0	NA	0	NA
Amador	214	0	NA	64	29.9	51	23.8	4	1.9	95	44.4
Butte	1,139	5	0.4	273	24.0	464	40.7	26	2.3	371	32.6
Calaveras	358	1	0.3	98	27.4	123	34.4	13	3.6	123	34.4
Colusa	68	0	NA	36	52.9	10	14.7	0	NA	22	32.4
Contra Costa	2,585	29	1.1	972	37.6	953	36.9	43	1.7	588	22.7
Del Norte	217	1	0.5	26	12.0	22	10.1	15	6.9	153	70.5
El Dorado	702	3	0.4	294	41.9	231	32.9	20	2.8	154	21.9
Fresno	2,582	31	1.2	472	18.3	1,025	39.7	27	1.0	1,027	39.8
Glenn	84	2	2.4	20	23.8	11	13.1	12	14.3	39	46.4
Humboldt	414	4	1.0	124	30.0	159	38.4	16	3.9	111	26.8
Imperial	576	1	0.2	167	29.0	151	26.2	17	3.0	240	41.7
Inyo	0	0	NA	0	NA	0	NA	0	NA	0	NA
Kern	2,804	18	0.6	1,234	44.0	908	32.4	35	1.2	609	21.7
Kings	606	5	0.8	109	18.0	190	31.4	0	NA	302	49.8
Lake	424	15	3.5	128	30.2	165	38.9	13	3.1	103	24.3
Lassen	212	0	NA	96	45.3	86	40.6	0	NA	30	14.2
Los Angeles	29,894	301	1.0	12,217	40.9	9,791	32.8	477	1.6	7,108	23.8
Madera	158	1	0.6	72	45.6	64	40.5	0	NA	21	13.3
Marin	146	6	4.1	53	36.3	44	30.1	0	NA	43	29.5
Mariposa	34	0	NA	12	35.3	9	26.5	5	14.7	8	23.5
Mendocino	426	10	2.3	117	27.5	143	33.6	36	8.5	120	28.2
Merced	850	1	0.1	289	34.0	299	35.2	12	1.4	249	29.3
Modoc	53	0	NA	33	62.3	20	37.7	0	NA	0	NA
Mono	*	*	*	*	*	*	*	*	*	*	*
Monterey	1,067	8	0.7	504	47.2	270	25.3	0	NA	285	26.7
Napa	265	0	NA	85	32.1	92	34.7	0	NA	88	33.2

continued on next page . . .

	TOTAL NUMBER OF FILLED PRESCRIPTIONS FOR PSYCHOTROPIC MEDICATIONS	ANTIANXIETY MEDICATIONS		ANTIDEPRESSANTS		ANTIPSYCHOTICS		MOOD STABILIZERS		STIMULANTS	
		NUMBER	PERCENT OF PRESCRIPTIONS	NUMBER	PERCENT OF PRESCRIPTIONS	NUMBER	PERCENT OF PRESCRIPTIONS	NUMBER	PERCENT OF PRESCRIPTIONS	NUMBER	PERCENT OF PRESCRIPTIONS
Nevada	212	1	0.5%	88	41.5%	32	15.1%	15	7.1%	76	35.8%
Orange	2,795	30	1.1	821	29.4	1,087	38.9	81	2.9	776	27.8
Placer	603	3	0.5	221	36.7	240	39.8	27	4.5	112	18.6
Plumas	95	0	NA	35	36.8	23	24.2	0	NA	37	38.9
Riverside	6,024	47	0.8	2,117	35.1	2,499	41.5	178	3.0	1,183	19.6
Sacramento	4,391	17	0.4	1,392	31.7	1,718	39.1	109	2.5	1,155	26.3
San Benito	105	0	NA	30	28.6	41	39.0	0	NA	34	32.4
San Bernardino	7,192	42	0.6	2,597	36.1	2,657	36.9	83	1.2	1,813	25.2
San Diego	4,898	70	1.4	1,736	35.4	1,487	30.4	87	1.8	1,518	31.0
San Francisco	1,749	11	0.6	672	38.4	525	30.0	70	4.0	471	26.9
San Joaquin	2,919	20	0.7	839	28.7	1,005	34.4	75	2.6	980	33.6
San Luis Obispo	977	17	1.7	256	26.2	371	38.0	47	4.8	286	29.3
San Mateo	607	7	1.2	291	47.9	206	33.9	8	1.3	95	15.7
Santa Barbara	1,185	4	0.3	351	29.6	433	36.5	5	0.4	392	33.1
Santa Clara	2,165	25	1.2	771	35.6	859	39.7	18	0.8	492	22.7
Santa Cruz	354	2	0.6	182	51.4	90	25.4	0	NA	80	22.6
Shasta	760	7	0.9	206	27.1	220	28.9	18	2.4	309	40.7
Sierra	*	*	*	*	*	*	*	*	*	*	*
Siskiyou	303	7	2.3	73	24.1	139	45.9	24	7.9	60	19.8
Solano	792	5	0.6	257	32.4	315	39.8	4	0.5	211	26.6
Sonoma	1,479	25	1.7	622	42.1	559	37.8	45	3.0	228	15.4
Stanislaus	1,138	7	0.6	448	39.4	392	34.4	11	1.0	280	24.6
Sutter	508	1	0.2	107	21.1	239	47.0	3	0.6	158	31.1
Tehama	266	0	NA	78	29.3	76	28.6	0	NA	112	42.1
Trinity	72	0	NA	19	26.4	32	44.4	0	NA	21	29.2
Tulare	1,913	27	1.4	476	24.9	607	31.7	60	3.1	743	38.8
Tuolumne	164	0	NA	51	31.1	71	43.3	10	6.1	32	19.5
Ventura	2,057	1	0.0	788	38.3	515	25.0	28	1.4	725	35.2
Yolo	422	12	2.8	174	41.2	106	25.1	19	4.5	111	26.3
Yuba	613	0	NA	164	26.8	321	52.4	21	3.4	107	17.5

Sources: California State Auditor's analysis of data obtained from the California Department of Social Services' Child Welfare Services/Case Management System and matched Medi-Cal pharmacy data.

NA = Not applicable.

* To protect individual privacy, we omitted this number because it would identify 10 or fewer foster children. Such omission is in accordance with aggregate data reporting guidelines issued by the Department of Health Care Services.

Table A-4 shows the number and proportion of foster children within certain age ranges who had psychotropic medication prescriptions filled during fiscal year 2014–15. As indicated in the Table, almost three-quarters of foster children with filled prescriptions for psychotropic medications were aged 12 to 17. County-level data mirrored the state results: most psychotropic medications in each county were also prescribed to foster children aged 12 to 17.

Table A-4

Number and Proportion of Children in Foster Care With Prescriptions for Psychotropic Medications That Were Filled in Fiscal Year 2014–15 by Age Range

			AGE RANGE							
	FISCAL YEAR 2014–15 TOTAL		0–1*		2–5*		6–11		12–17	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Statewide	9,317	100.0%	17	0.2%	217	2.3%	2,604	27.9%	6,895	74.0%
Counties										
Alameda	298	3.2%					44	14.8%	254	85.2%
Butte	76	0.8					31	40.8	50	65.8
Calaveras	26	0.3					11	42.3	17	65.4
Contra Costa	215	2.3					45	20.9	175	81.4
El Dorado	69	0.7					16	23.2	54	78.3
Fresno	246	2.6					84	34.1	168	68.3
Humboldt	43	0.5					12	27.9	31	72.1
Imperial	75	0.8					30	40.0	43	57.3
Kern	249	2.7					61	24.5	193	77.5
Kings	51	0.5					22	43.1	31	60.8
Los Angeles	3,194	34.3					924	28.9	2,336	73.1
Merced	81	0.9					18	22.2	62	76.5
Monterey	94	1.0					19	20.2	72	76.6
Orange	257	2.8					66	25.7	201	78.2
Placer	56	0.6					16	28.6	41	73.2
Riverside	595	6.4					165	27.7	440	73.9
Sacramento	424	4.6					100	23.6	335	79.0
San Bernardino	660	7.1					213	32.3	460	69.7
San Diego	475	5.1					130	27.4	348	73.3
San Francisco	150	1.6					46	30.7	115	76.7
San Joaquin	248	2.7					88	35.5	168	67.7
San Luis Obispo	79	0.8					20	25.3	58	73.4
San Mateo	69	0.7					13	18.8	58	84.1
Santa Barbara	103	1.1					36	35.0	71	68.9
Santa Clara	213	2.3					40	18.8	178	83.6
Shasta	96	1.0					42	43.8	59	61.5
Solano	85	0.9					20	23.5	70	82.4
Sonoma	140	1.5					21	15.0	121	86.4
Stanislaus	117	1.3					27	23.1	90	76.9
Sutter	36	0.4					13	36.1	25	69.4
Tehama	33	0.4					11	33.3	22	66.7
Tulare	165	1.8					64	38.8	97	58.8
Ventura	153	1.6					38	24.8	120	78.4
Yuba	40	0.4					16	40.0	28	70.0
Other counties	406	4.4					102	25.1	304	74.9

Sources: California State Auditor's analysis of data obtained from the California Department of Social Services' Child Welfare Services/Case Management System and matched Medi-Cal pharmacy data.

Notes: Totals may not add up to 100 percent because some children aged into a new age range during fiscal year 2014–15.

The term *foster children* refers to children aged zero to 17 in the foster care system.

* The 0–1 year and 2–5 years age ranges for each county contained 10 or fewer foster children in at least one of the two age ranges. To protect individual privacy, we omitted all county data for these two columns.

Table A-5 shows the number of foster children in each age range who had filled antipsychotic medication prescriptions in fiscal year 2014–15. Similar to Table A-4, the majority of foster children with filled prescriptions for antipsychotic medications were aged 12 to 17. Again, county-level data mirrored the state results.

Table A-5
Number and Proportion of Children in Foster Care With Prescriptions for Antipsychotic Psychotropic Medications That Were Filled in Fiscal Year 2014–15 by Age Range

	NUMBER OF FOSTER CHILDREN WITH FILLED PRESCRIPTIONS FOR PSYCHOTROPIC MEDICATIONS	FOSTER CHILDREN WITH FILLED PRESCRIPTIONS FOR ANTIPSYCHOTICS		AGE RANGE			
				0–1*	2–5*	6–11	12–17
		NUMBER	PERCENT	NUMBER	NUMBER	NUMBER	NUMBER
Statewide	9,317	4,339	46.6%			1,069	3,380
Counties							
Alameda	298	147	49.3%			20	127
Butte	76	44	57.9			18	30
Contra Costa	215	108	50.2			17	95
Fresno	246	108	43.9			25	84
Kern	249	122	49.0			26	98
Los Angeles	3,194	1,409	44.1			389	1,051
Orange	257	127	49.4			33	98
Riverside	595	342	57.5			82	271
Sacramento	424	214	50.5			39	178
San Bernardino	660	359	54.4			87	279
San Diego	475	190	40.0			34	160
San Francisco	150	56	37.3			21	40
San Joaquin	248	111	44.8			37	82
San Luis Obispo	79	47	59.5			13	34
Santa Barbara	103	49	47.6			17	35
Santa Clara	213	108	50.7			19	91
Shasta	96	32	33.3			12	21
Tulare	165	71	43.0			23	51
Yuba	40	29	72.5			13	20
Other counties	1,534	666	43.4			144	535

Sources: California State Auditor's analysis of data obtained from the California Department of Social Services' Child Welfare Services/Case Management System and matched Medi-Cal pharmacy data.

Notes: Total percentages may not add up to 100 percent because some children aged into a new age range during fiscal year 2014–15.

The term *foster children* refers to children aged zero to 17 in the foster care system.

* The 0-to-1 year and 2-to-5 years age ranges for each county and the State contained fewer than 10 foster children in at least one of the two age ranges. To protect individual privacy, we omitted all data for these two columns.

Table A-6 shows the number and proportion of foster children in fiscal year 2014–15 who had filled prescriptions for more than one psychotropic medication in the same class for antidepressants, antipsychotics, and stimulants, the three most widely prescribed classifications from Table A-3. The data reflect that it is more common for foster children to be on multiple antidepressants than on multiple antipsychotics or multiple stimulants. The county-level data show the same trend as the statewide data.

Table A-6
Number and Proportion of Children in Foster Care With Multiple Filled Psychotropic Medication Prescriptions From the Same Class, Statewide and by County, Fiscal Year 2014–15

	TOTAL NUMBER OF FOSTER CHILDREN WITH FILLED PSYCHOTROPIC MEDICATION PRESCRIPTIONS	FOSTER CHILDREN WITH FILLED PRESCRIPTIONS FOR MORE THAN ONE ANTIDEPRESSANT*		FOSTER CHILDREN WITH FILLED PRESCRIPTIONS FOR MORE THAN ONE ANTIPSYCHOTIC*		FOSTER CHILDREN WITH FILLED PRESCRIPTIONS FOR MORE THAN ONE STIMULANT*	
		NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Statewide	9,317	851	9.1%	330	3.5%	193	2.1%
Counties							
Alameda	298	36	12.1%	13	4.4%	†	†
Contra Costa	215	21	9.8	†	†	†	†
Fresno	246	†	†	21	8.5	†	†
Kern	249	63	25.3	14	5.6	†	†
Los Angeles	3,194	267	8.4	69	2.2	42	1.3%
Monterey	94	14	14.9	†	†	†	†
Orange	257	12	4.7	18	7.0	†	†
Riverside	595	71	11.9	26	4.4	†	†
Sacramento	424	25	5.9	21	5.0	†	†
San Bernardino	660	86	13.0	13	2.0	†	†
San Diego	475	37	7.8	19	4.0	13	2.7
San Joaquin	248	17	6.9	11	4.4	†	†
Santa Clara	213	19	8.9	†	†	†	†
Sonoma	140	25	17.9	†	†	†	†
Tulare	165	†	†	†	†	11	6.7
Ventura	153	22	14.4	†	†	18	11.8
Other counties	1,691	116	6.9	72	4.3	45	2.7

Sources: California State Auditor's analysis of data obtained from the Department of Health Care Services' California Medicaid Management Information System, data obtained from the California Department of Social Services' Child Welfare Services/Case Management System, and matched Medi-Cal pharmacy data.

Note: The term *foster children* refers to children aged zero to 17 in the foster care system.

* For our analysis, we only considered foster children to be on more than one psychotropic medication if they received more than one psychotropic medication within the same medication classification for more than 30 days.

† To protect individual privacy, we omitted this number because it would identify 10 or fewer foster children. Such omission is in accordance with aggregate data reporting guidelines issued by the Department of Health Care Services.

Table A-7 shows the number of foster children by age range in fiscal year 2014–15 whose number of filled prescriptions for psychotropic medications exceeded Social Services and Health Care Services' guidelines for the safe administration of psychotropic medications to foster children.

Table A-7
Number of Children in Foster Care With Filled Prescriptions for Psychotropic Medications That Exceeded the State's Recommended Guidelines for Age Groups, Statewide and by County, Fiscal Year 2014–15

	TOTAL NUMBER OF FOSTER CHILDREN PRESCRIBED PSYCHOTROPIC MEDICATIONS	FOSTER CHILDREN AGE 0-5 PRESCRIBED MORE THAN ONE PSYCHOTROPIC MEDICATION*	FOSTER CHILDREN AGE 6-11 PRESCRIBED MORE THAN TWO PSYCHOTROPIC MEDICATIONS*	FOSTER CHILDREN AGE 12-17 PRESCRIBED MORE THAN THREE PSYCHOTROPIC MEDICATIONS*
Statewide	9,317	29	159	90
Counties				
Kern	249	†	12	†
Los Angeles	3,194	†	34	14
Riverside	595	†	†	11
San Bernardino	660	†	17	†
Other Counties	4,619	17	†	55

Sources: California State Auditor's analysis of data obtained from the Department of Health Care Services' California Medicaid Management Information System, data obtained from the California Department of Social Services' Child Welfare Services/Case Management System, and matched Medi-Cal pharmacy data.

Notes: State guidelines recommend that children aged zero to 5 take no more than one psychotropic medication, children aged 6 to 11 take no more than two psychotropic medications, and children aged 12 to 17 take no more than three psychotropic medications.

The term *foster children* refers to children aged zero to 17 in the foster care system.

* For our analysis, we considered foster children to be on multiple psychotropic medications when their prescriptions overlapped for more than 30 consecutive days.

† To protect individual privacy, we omitted this number because it would identify 10 or fewer foster children. Such omission is in accordance with aggregate data reporting guidelines issued by the Department of Health Care Services.

Table A-8 shows the number of foster children in fiscal year 2013–14 who did not have follow-up medical appointments within 30 days after starting at least one new psychotropic medication. As the Table indicates, more than 29 percent of foster children who started new psychotropic medications did not have a corresponding Medi-Cal claim for a follow-up medication service visit.

Table A-8
Number and Proportion of Children in Foster Care With New Psychotropic Medication Prescriptions Filled in Fiscal Year 2013–14 Without a Corresponding Medi-Cal Claim for a Follow-Up Medication Service Within 30 Days, Statewide and by County

	NUMBER OF FOSTER CHILDREN WITH NEW PSYCHOTROPIC MEDICATION PRESCRIPTIONS*	NUMBER OF FOSTER CHILDREN WITH AT LEAST ONE FILLED PRESCRIPTION FOR A NEW PSYCHOTROPIC MEDICATION WITHOUT A CORRESPONDING MEDI-CAL CLAIM FOR A FOLLOW-UP MEDICATION SERVICE	
		NUMBER	PERCENT
Statewide	6,471	1,881	29.1%
Counties			
Alameda	220	73	33.2%
Butte	54	20	37.0
Calaveras	17	†	†
Contra Costa	136	37	27.2%

	NUMBER OF FOSTER CHILDREN WITH NEW PSYCHOTROPIC MEDICATION PRESCRIPTIONS*	NUMBER OF FOSTER CHILDREN WITH AT LEAST ONE FILLED PRESCRIPTION FOR A NEW PSYCHOTROPIC MEDICATION WITHOUT A CORRESPONDING MEDI-CAL CLAIM FOR A FOLLOW-UP MEDICATION SERVICE	
		NUMBER	PERCENT
Del Norte	12	†	†
El Dorado	43	17	39.5
Fresno	156	63	40.4
Glenn	13	†	†
Humboldt	28	†	†
Imperial	60	39	65.0
Kern	158	58	36.7
Kings	31	17	54.8
Lake	20	†	†
Lassen	16	†	†
Los Angeles	2,252	334	14.8
Madera	17	†	†
Mendocino	32	15	46.9
Merced	50	27	54.0
Monterey	62	23	37.1
Napa	26	15	57.7
Orange	186	45	24.2
Placer	39	13	33.3
Riverside	406	167	41.1
Sacramento	283	83	29.3
San Bernardino	454	228	50.2
San Diego	372	86	23.1
San Francisco	116	28	24.1
San Joaquin	160	60	37.5
San Luis Obispo	58	21	36.2
San Mateo	45	22	48.9
Santa Barbara	63	25	39.7
Santa Clara	125	27	21.6
Santa Cruz	42	13	31.0
Shasta	75	20	26.7
Siskiyou	20	†	†
Solano	60	26	43.3
Sonoma	90	46	51.1
Stanislaus	80	39	48.8
Sutter	25	†	†
Tehama	35	13	37.1
Tulare	101	30	29.7
Ventura	114	19	16.7
Yolo	25	12	48.0
Yuba	24	†	†
Other counties	70	36	51.4

Sources: California State Auditor's analysis of data obtained from the Department of Health Care Services' Paid Claims and Encounters System, data obtained from the California Department of Social Services' Child Welfare Services/Case Management System, and matched Medi-Cal pharmacy data.

Notes: The term *foster children* refers to children aged zero to 17 in the foster care system.

* We defined a *new prescription* as any prescription for a psychotropic medication that the child had not been prescribed in the prior 120 days and, as discussed in the Scope and Methodology section on page 17, we applied the National Committee for Quality Assurance's methodology for follow-up care.

† To protect individual privacy, we omitted this number because it would identify 10 or fewer foster children. Such omission is in accordance with aggregate data reporting guidelines issued by the Department of Health Care Services.

Table A-9 shows the number of foster children in fiscal year 2013–14 who had at least one instance in which they did not receive psychosocial services within 30 days, either before or after receiving a prescription for psychotropic medications. In addition, Table A-9 shows the number of foster children in the same fiscal year who had at least one instance in which they did not receive psychosocial services within 180 days, either before or after beginning a new prescription. As shown in the Table, between 3,965 and 7,489 (41 and 77 percent) of foster children statewide had at least one instance in which they did not receive corresponding psychosocial services within 30 days of receiving a prescription. We report a range in the number of foster children who did not receive psychosocial services to accommodate for differences in the way the Department of Health Care Services and the National Committee for Quality Assurance use procedure codes to define psychosocial services.

Further, when compiling statewide data, we found that Social Services' data is not formatted in a way that allows us to definitively identify if court authorizations or parental consents are associated with a specific psychotropic medication. As a result, we analyzed the statewide data to identify the frequency with which court authorizations or parental consents existed for any medication and if that approval was either 180 days before or 30 days after the date the psychotropic medication prescription was filled. Table A-10 on page 94 shows the number and proportion of foster children in fiscal year 2014–15 who had prescriptions filled for psychotropic medications and the type of authorization they received. As the data show, only 35 percent of the foster children statewide had court authorizations or parental consents for all their psychotropic medications. The other 65 percent were missing authorizations or consents for at least one psychotropic medication. Further, only 11 of the 35 counties shown had court authorizations or parental consents rates of 50 percent or more for all psychotropic medications prescribed for foster children.

Table A-9
Number of Children in Foster Care With Filled Prescriptions for Psychotropic Medications Without a Corresponding Medi-Cal Claim for Psychosocial Services, Statewide and by County, Fiscal Year 2013–14

	FOSTER CHILDREN WITH FILLED PRESCRIPTIONS FOR PSYCHOTROPIC MEDICATIONS	NUMBER OF FOSTER CHILDREN WITH AT LEAST ONE INSTANCE OF NO SERVICE WITHIN...	
		...30 DAYS BEFORE OR AFTER FILLING A PRESCRIPTION	...180 DAYS BEFORE OR AFTER FILLING A PRESCRIPTION
Statewide	9,707	3,965–7,489	1,564–4,512
Counties			
Alameda	323	134–242	44–131

	FOSTER CHILDREN WITH FILLED PRESCRIPTIONS FOR PSYCHOTROPIC MEDICATIONS	NUMBER OF FOSTER CHILDREN WITH AT LEAST ONE INSTANCE OF NO SERVICE WITHIN...	
		...30 DAYS BEFORE OR AFTER FILLING A PRESCRIPTION	...180 DAYS BEFORE OR AFTER FILLING A PRESCRIPTION
Butte	85	44–*	14–65
Contra Costa	221	88–165	32–118
El Dorado	64	37–*	23–*
Fresno	234	118–193	59–118
Humboldt	38	17–*	*–14
Imperial	68	47–*	21–56
Kern	253	124–210	48–134
Kings	46	33–*	15–33
Lake	34	*–*	*–15
Los Angeles	3,267	742–2,185	204–994
Mendocino	55	25–*	14–43
Merced	85	53–73	24–50
Monterey	116	51–82	*–36
Napa	36	22–*	13–*
Orange	301	107–275	46–210
Placer	57	32–45	16–30
Riverside	600	385–556	146–363
Sacramento	456	196–367	80–225
San Bernardino	680	442–545	196–343
San Diego	548	206–349	92–224
San Francisco	183	59–103	26–42
San Joaquin	269	116–252	65–184
San Luis Obispo	86	37–63	18–31
San Mateo	66	31–*	*–32
Santa Barbara	102	59–83	35–61
Santa Clara	205	73–180	27–118
Santa Cruz	56	16–43	*–23
Shasta	113	57–*	12–91
Siskiyou	27	*–*	12–*
Solano	86	40–*	*–53
Sonoma	142	98–*	56–98
Stanislaus	116	60–103	29–76
Sutter	40	16–*	*–20
Tehama	41	21–*	*–*
Tulare	166	72–142	34–80
Ventura	167	44–124	16–74
Yolo	41	*–*	21–*
Yuba	36	20–*	*–19
Other counties	198	131–175	61–137

Sources: California State Auditor's analysis of data obtained from the Department of Health Care Services' Paid Claims and Encounters System, data obtained from the California Department of Social Services' Child Welfare Services/Case Management System, and matched Medi-Cal pharmacy data.

Note: The term *foster children* refers to children aged zero to 17 in the foster care system.

* To protect individual privacy, we omitted this number because it would identify 10 or fewer foster children. Such omission is in accordance with aggregate data reporting guidelines issued by the Department of Health Care Services.

Table A-10

Number and Proportion of Children in Foster Care With Filled Prescriptions for Psychotropic Medications by Type of Consent Recorded in Social Services' Data, Statewide and by County, Fiscal Year 2014–15

	TOTAL NUMBER OF FOSTER CHILDREN WITH FILLED PRESCRIPTIONS FOR PSYCHOTROPIC MEDICATIONS IN FISCAL YEAR 2014–15		TYPES OF CONSENT					
			COURT AUTHORIZATION OR PARENTAL CONSENT FOR ALL PSYCHOTROPIC MEDICATIONS		NO COURT AUTHORIZATION OR PARENTAL CONSENT FOR ANY PSYCHOTROPIC MEDICATIONS		NO COURT AUTHORIZATION OR PARENTAL CONSENT FOR ONE OR MORE PSYCHOTROPIC MEDICATIONS	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Statewide	9,317	100.0%	3,232	34.7%	3,448	37.0%	6,085	65.3%
Counties								
Alameda	298	3.2%	39	13.1%	174	58.4%	259	86.9%
Butte	76	0.8	21	27.6	12	15.8	55	72.4
Fresno	246	2.6	141	57.3	58	23.6	105	42.7
Humboldt	43	0.5	28	65.1	13	30.2	15	34.9
Imperial	75	0.8	14	18.7	29	38.7	61	81.3
Kern	249	2.7	143	57.4	54	21.7	106	42.6
Kings	51	0.5	17	33.3	18	35.3	34	66.7
Lake	33	0.4	13	39.4	11	33.3	20	60.6
Los Angeles	3,194	34.3	920	28.8	1,475	46.2	2,274	71.2
Mendocino	48	0.5	25	52.1	*	*	23	47.9
Merced	81	0.9	31	38.3	28	34.6	50	61.7
Monterey	94	1.0	57	60.6	*	*	37	39.4
Napa	30	0.3	13	43.3	*	*	17	56.7
Orange	257	2.8	106	41.2	51	19.8	151	58.8
Placer	56	0.6	16	28.6	24	42.9	40	71.4
Riverside	595	6.4	300	50.4	121	20.3	295	49.6
Sacramento	424	4.6	176	41.5	135	31.8	248	58.5
San Bernardino	660	7.1	227	34.4	201	30.5	433	65.6
San Diego	475	5.1	227	47.8	133	28.0	248	52.2
San Francisco	150	1.6	76	50.7	34	22.7	74	49.3
San Joaquin	248	2.7	108	43.5	54	21.8	140	56.5
San Luis Obispo	79	0.8	15	19.0	21	26.6	64	81.0
San Mateo	69	0.7	29	42.0	12	17.4	40	58.0
Santa Barbara	103	1.1	56	54.4	23	22.3	47	45.6
Santa Clara	213	2.3	50	23.5	69	32.4	163	76.5
Santa Cruz	43	0.5	18	41.9	15	34.9	25	58.1
Shasta	96	1.0	76	79.2	*	*	20	20.8
Solano	85	0.9	29	34.1	33	38.8	56	65.9
Sonoma	140	1.5	31	22.1	65	46.4	109	77.9
Stanislaus	117	1.3	12	10.3	65	55.6	105	89.7
Sutter	36	0.4	21	58.3	*	*	15	41.7
Tehama	33	0.4	13	39.4	*	*	20	60.6
Tulare	165	1.8	17	10.3	73	44.2	148	89.7
Ventura	153	1.6	65	42.5	25	16.3	88	57.5
Yuba	40	0.4	23	57.5	*	*	17	42.5
Other counties	562	6.0	79	14.1	369	65.7	483	85.9

Sources: California State Auditor's analysis of data obtained from the California Department of Social Services' Child Welfare Services/Case Management System and matched Medi-Cal pharmacy data.

Note: The term *foster children* refers to children aged zero to 17 in the foster care system.

* To protect individual privacy, we omitted this number because it would identify 10 or fewer foster children. Such omission is in accordance with aggregate data reporting guidelines issued by the Department of Health Care Services.

CDSS
WILL LIGHTBOURNE
DIRECTOR

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES
744 P Street • Sacramento, CA 95814 • www.cdss.ca.gov

EDMUND G. BROWN JR.
GOVERNOR

June 6, 2016

Ms. Elaine M. Howle, State Auditor*
California State Auditor
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Dear Ms. Howle:

SUBJECT: CALIFORNIA'S FOSTER CARE SYSTEM: THE STATE AND (REDACTED) HAVE FAILED TO ADEQUATELY OVERSEE THE PRESCRIPTION OF PSYCHOTROPIC MEDICATIONS TO CHILDREN IN FOSTER CARE 2015-131

This letter provides the California Department of Social Services' (CDSS) initial response to the California State Auditor's Office draft of the above entitled report.

If you have any questions concerning the enclosed CDSS response, please contact me at (916) 657-2598 or Cynthia Fair, Audits Bureau Chief, at (916) 651-9923.

Sincerely,

WILL LIGHTBOURNE
Director

Enclosure

* California State Auditor's comment appears on page 103.

California Department of Social Services (CDSS)
RESPONSES TO AUDIT RECOMMENDATIONS

California State Auditor (CSA)

Audit #: 2015-131

Audit Title: ***The State and (redacted) Have Failed to Adequately Oversee the Prescription of Psychotropic Medications to Children in Foster Care***

Recommendations for Social Services:

Recommendation 1:

To better ensure that counties only use parental consent in place of court authorization when it is appropriate, Social Services should assess _(redacted)_ County's practice of advocating to the juvenile court that it delegate to parents the authority to administer psychotropic medications to foster children.

CDSS Initial Response:

CDSS will commit to the following activities to assess the issue of reliance on parental consent regarding psychotropic medication usage:

- Meet with the county's Child Welfare Director and other relevant county staff to discuss their current practice of advocating to the Juvenile Court that parents be given the authority to retain their rights to make final decisions about their child's usage of psychotropic medication;
- Determine mutually agreed upon protocols for determining appropriateness of recommending parental consent versus court authorization for psychotropic medication prescriptions;
- Provide support and technical assistance to the county as they implement new protocols;
- Explore with county partners the option to extend psychiatric review (if available) of psychotropic medication prescriptions for youth whose parent(s) retain rights to consent to its usage; and
- If it is determined to be necessary, assist in the development of procedures to ensure parent(s) are provided with feedback from the psychiatrist conducting the review so that they may make informed decisions about their child's use of these medications.

Recommendation 2:

To better ensure that all caregivers are informed and educated regarding the use of psychotropic medications and the court authorization process, Social Services should develop instructions regarding these topics and provide them to caregivers that do not operate group homes, such as foster family agencies.

CDSS Initial Response:

Anticipated Implementation Date: Summer 2016. The Department developed a Medication Guide for Group Home providers to be aware of best practices as well as statutory and regulatory requirements through applicable scenarios and additional recommendations regarding the use of psychotropic medications and the court authorization process. This Medication Guide was published on December 31, 2015. A similar guide, specific to Foster Family Agencies, is currently under review and an additional guide, for Foster Family Homes, will soon be under development.

The Department strives to promote improvement and efficiency throughout the licensing system, and while the guides cannot be used as a substitute for understanding and complying with the laws governing a licensee's license to operate, they do offer assistance in clarifying good practice for additional safeguards for medications within the providers' facilities and homes.

Recommendation 3:

To improve the State and counties' oversight of psychotropic medications prescribed to foster children, including the accuracy and completeness of its data system and foster children's health and education passports, Social Services should collaborate with counties and other relevant shareholders – such as Health Care Services, as applicable – to develop and implement a reasonable oversight structure. This structure should include at least the following items:

- *Identification of the specific oversight responsibilities to be performed by the various state and local government agencies.*
- *An agreement on how county staff – including social workers, probation officers, and public health nurses – will use printed health and education passports to obtain foster children's necessary mental health information – including psychotropic medications and mental health services – for inclusion in Social Services' data system.*
- *A plan to ensure that counties have sufficient number of staff available to enter foster children's mental health information into Social Services' data system, and the resources to pay for those staff.*
- *An agreement on the specific information related to psychotropic medication – including but not limited to medication name, maximum daily dosage, and court authorization date – and mental health services information that county staff must enter into Social Services' data system for inclusion in foster children's health and education passports.*

- *Specific directions from Social Services regarding the correct medication start dates and court authorization dates to include in its data system and foster children's health and education passports.*
- *An agreement on the training or guidance Social Services should provide to ensure that county staff members working with Social Services' data system know how to completely and accurately update foster children's health and education passports.*
- *An agreement that the counties will implement the new forms that the Judicial Council approved regarding the authorization of psychotropic medications for foster children.*
- *An agreement regarding how counties will implement, use, or disseminate the educational and informational materials the Quality Improvement Project produced including the California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care, Questions to Ask About Medications, and the Foster Youth Mental Health Bill of Rights.*
- *An agreement on the specific measures the State and counties will use to assess outcomes related to psychotropic medications prescribed to foster children.*
- *An agreement on how the State and counties will oversee psychotropic medications prescribed to foster children by those fee-for-service providers not affiliated with county Medi-Cal mental health plans.*
- *An agreement on the extent of information related to psychotropic medications prescribed to foster children that counties will include in their self assessments, system improvement plans, and annual progress reports developed as part of Social Services' California Child and Family Services Reviews.*
- *An agreement on the extent of the information related to psychotropic medications prescribed to foster children that counties will include in their responses to Health Care Services' reviews, including county Medi-Cal mental health plan compliance reviews and external quality reviews.*

CDSS Initial Response:

CDSS agrees that improvements can be made to the quality and accuracy of mental health information documented in the Child Welfare Services/Case Management System (CWS/CMS). CDSS also recognizes that counties may provide this information to caregivers, health providers, and mental health clinicians via other documents in addition to the Health Education Passport (HEP).

CDSS will employ the following strategies to develop and implement a statewide oversight structure to ensure improved data entry into the CWS/CMS system and more efficient oversight and monitoring of psychotropic medication use by foster youth at both the state and local level:

- Utilize existing and ongoing meetings with the California Child Welfare Director's Association (CWDA) to collaborate with the Department of Health Care Services (DHCS), county child welfare and probation agencies, and relevant stakeholders to:
  - identify roles and responsibilities at the state and local level;

- develop collective guidance and best practices between CDSS and counties to address:
  - data entry challenges,
  - appropriate use of the HEP for conveying information regarding the child's health, mental health and education information,
  - appropriate documents to be provided in addition to the HEP,
  - optimal training for social workers, probation officers and public health nurses regarding data entry for health and education notebooks in CWS/CMS,
  - implementation of new Judicial Council court authorization forms,
  - dissemination and use of Quality Improvement Plan (QIP) educational materials, *California Guidelines for the Use of Psychotropic Medications With Children and Youth in Foster Care*, and the *Foster Youth Mental Health Bill of Rights/ Questions to Ask About Medications* (PUB 488) brochure,
  - oversight of prescriptions to foster children served by providers outside of the county Medi-Cal mental health plans,
  - how information will be included by counties in their responses to Health Care Services reviews including Medi-Cal mental health compliance reviews and external quality reviews,

- Meet with counties to explore additional funding options, repurposing of current funding streams, and/or increasing efficiency among current staff resources to ensure children's mental health information is entered into CWS/CMS;

- Issue guidance and instructions to counties via an All County Information Notice regarding entry of medication data into CWS/CMS specifically outlining the importance of medication name, medication start date, court authorization date, and mental health information;

- Explore with DHCS the development of a report, for signatory counties to the Global Data Sharing Agreement, to identify children receiving a paid claim for a medication in a dosage that exceeds the recommended maximum daily dosage recommended in the state guidelines.

- Revise methodology for reconciliation reports which are currently being provided to counties to add medication start date as a way to ensure non-emergency prescriptions are not being filled prior to court authorizations;

- Add a medication/mental health information data entry focus to training being developed to meet the mandates of Senate Bill 238 (Chapter 534, Statutes 2015) which requires CDSS in consultation with stakeholders to develop and make available training for social workers, probation officers, court staff, children's attorneys, children's caregivers, and Court Appointed Special Advocates;

  - Training will address authorization, uses, risks, benefits, assistance with self-administration, oversight, and monitoring of psychotropic medications,

trauma and substance use disorder treatments, and how to access those treatments.

- Encourage counties to include psychotropic medication oversight in their self-assessments and system improvement plans; and

- Require counties to include psychotropic medication oversight in their California Child and Family Services Review (C-CFSR) annual progress reports.

SB 238 outlined a set of measures the state and counties will use to assess outcomes related to psychotropic medications. In addition to the Youth Authorized for Psychotropic Medication (Measure 5f) cited in the report, CDSS provided the Auditor with the seven child welfare psychotropic medication measures that were developed through the Quality Improvement Project.

This audit report cited that one of the limitations of Measure 5f was that the measure does not identify the number of children actually prescribed medications. However, the report failed to acknowledge that CDSS has been regularly publishing two of the seven measures noted above since October 2015, Use of Psychotropic and Antipsychotic Medications (Measure 5a.1 and Measure 5a.2) on the California Child Welfare Indicators Project website. Using matched DHCS and CDSS data, these measures identify youth in foster care who received a Medi-Cal paid prescription for psychotropic medication while the youth were in out-of-home care. These measures are produced with refreshed data every three months and provide stratifications by geographic region, county, supervising agency, placement type, age group at the time of the prescription, gender, and ethnic group. ①

The remaining five measures are: Use of Concurrent Psychotropic Medications (Measure 5c), Ongoing Metabolic Monitoring for Youth in Foster Care on Antipsychotic Medication (Measure 5d), Use of First-Line Psychosocial Care for Youth in Foster Care on Psychotropic Medication (Measure 5e), Follow-Up Visit for Youth in Foster Care on Psychotropic Medication (Measure 5g), and Metabolic Screening for Youth in Foster Care Newly on Antipsychotic Medication (Measure 5h).

As of May 25, 2016, CDSS staff was granted access to a shared data environment to identify the full population of children in foster care within DHCS' data system. This shared data environment will facilitate the development and publication of the remaining measures.

Recommendation 4:

To ensure that the Medical Board can complete promptly its analysis to identify physicians who may have inappropriately prescribed psychotropic medications to foster youth, Social Services and Health Care Services should continue to work with the Medical Board and its consultant to meet its data needs. To the extent that the Medical Board's analysis is able to identify these physicians, Social Services and Health Care Services should enter into a future agreement with the Medical Board to continue providing information for the Medical Board's data needs.

CDSS Initial Response:

In April 2015, CDSS, DHCS, and the Medical Board of California (MBC) entered into a data use agreement in order for the MBC to acquire the necessary data to exercise its statutory authority as an oversight entity. As of May 4, 2016, CDSS has transmitted the additional data requested by the MBC to DHCS to be included in the dataset provided by DHCS to the MBC.

To the extent that the MBC is successful in its analysis, CDSS agrees to extend, and amend as necessary, the existing data use agreement in order to ensure data is provided promptly and on a regular basis.

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Comment

CALIFORNIA STATE AUDITOR'S COMMENT ON THE RESPONSE FROM THE CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

To provide clarity and perspective, we are commenting on the response from the California Department of Social Services (Social Services) to the audit. The number below corresponds to the number we have placed in the margin of its response.

1 Our audit report did not "fail to acknowledge" measures 5a.1 (use of psychotropic medications by foster children) and 5a.2 (use of antipsychotic medications by foster children) as Social Services asserts; we intentionally omitted them. On page 66 of our report, we indicate that only one measure—5F—published on the website for the California Child Welfare Indicators Project addresses the number of foster children authorized to receive psychotropic medications. Despite Social Services' statement that measures 5a.1 and 5a.2 have been published since October 2015, Social Services waited until April 2016 to inform counties of their availability through an all-county letter. In an all-county letter to county child welfare directors and other county officials dated April 28, 2016, Social Services mentioned that county child welfare and probation agencies could view the results of these two measures at the California Child Welfare Indicators Project website. Because the contents of the all-county letter had no direct bearing on our report's findings, conclusions, or recommendations, we opted to not mention the two new measures.

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DHCS

JENNIFER KENT
Director

State of California—Health and Human Services Agency
Department of Health Care Services

EDMUND G. BROWN JR.
Governor

Ms. Elaine M. Howle
California State Auditor
621 Capitol Mall, Suite 1200
Sacramento, CA 95814

Dear Ms. Howle:

The California Department of Health Care Services (DHCS) hereby provides response to the draft findings of the California State Auditor's (CSA) report entitled, *California's Foster Care System: The State and [redacted] Have Failed to Adequately Oversee the Prescription of Psychotropic Medications to Children in Foster Care*. The CSA conducted this audit and issued two (2) findings and two (2) recommendations.

DHCS agrees with the recommendations and has prepared corrective action plans to implement them. DHCS appreciates the work performed by CSA and the opportunity to respond to the findings. If you have any questions, please contact Ms. Sarah Hollister, Audit Coordinator, at (916) 650-0298.

Sincerely,

Jennifer Kent
Director

Enclosure

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Department of Health Care Services Response to: The California State Auditor's Report entitled, *California's Foster Care System: The State and [redacted] Failed to Adequately Oversee the Prescription of Psychotropic Medications to Children in Foster Care*

Finding #1: **Fragmented oversight and poor data hamper state and county efforts to ensure appropriate prescribing of psychotropic medications.**

Recommendation 1: **To ensure the Medical Board can complete promptly, its analysis to identify physicians who may have inappropriately prescribed psychotropic medications to foster youth, CDSS and DHCS should continue to work with the Medical Board and its consultants to meet its data needs.**

Response: DHCS agrees with the recommendation.

DHCS and CDSS are providing additional data to the Medical Board by mid-June, 2016 as requested by the Medical Board under an existing Data Use Agreement. DHCS will provide data, to the extent that it is data that DHCS has, to the Medical Board beyond the initial evaluation if the Medical Board requests it.

Finding #2: **DHCS does not ensure pharmacists obtain its approval before they dispense psychotropic medications to foster children for off-label uses.**

Recommendation 2: **To increase the State's assurance that foster children do not receive medically inappropriate or unnecessary psychotropic medications, DHCS should devise and implement within six months, methods to better enforce its prior authorization requirements for off label use of psychotropic medications.**

Response: DHCS agrees with the recommendation.

DHCS will research the FDA approved age limitations on all psychotropic medications and implement edits within the claims system that will alert the dispensing pharmacy that the age of the patient requires that an approved Treatment Authorization Request (TAR) be obtained prior to billing for the requested medication. The necessary research into the FDA approved age limitations for all dosage forms and strengths of all psychotropic medications will take approximately 3 months before the edits can then be appropriately implemented in the claims processing system approximately 3 months later.

As part of the notification process for all changes in benefit, pharmacy and medical providers will also be reminded in the provider bulletin publications that all off-label use of drugs requires a TAR and that, in particular, psychotropic medications used in the juvenile population should be verified to be FDA approved and age appropriate prior to dispensing the medication. Pharmacy Benefits staff will work with Audits and Investigation staff to explore possible onsite inspection protocols specific to off-label utilization of medications. DHCS estimates implementation of these corrective actions within the six-months.

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY - *Department of Consumer Affairs* EDMUND G. BROWN JR, *Governor*

MEDICAL BOARD OF CALIFORNIA
Executive Office

June 6, 2016

Elaine M. Howle
California State Auditor
Bureau of State Audits
621 Capitol Mall, Suite 1200
Sacramento, CA 95814

Re.: Draft Audit Report 2015-131 – California's Oversight of Psychotropic Medications Prescribed to Children in Foster Care

Dear Ms. Howle:

The Medical Board of California (Board) is in receipt of your draft audit report regarding California's oversight of psychotropic medications prescribed to children in foster care. The Board received the portions of the draft audit related to the Medical Board. I would like to thank the Bureau of State Audits for conducting this audit and for allowing the Board to respond to the issues presented in the audit report. The Board agrees that a proactive approach to this issue is essential in order to ensure appropriate prescribing to foster children. The Board has been working on this issue and, as stated in the report, is currently under a data usage agreement (DUA) with the Department of Health Care Services (DHCS) and the Department of Social Services (DSS) to obtain specified prescribing information for foster children. The Board is currently waiting for additional information that is necessary for the Board's consultant to perform the desired data analysis assessment. This additional information was originally requested from DHCS and DSS by the Board in February 2016.

In addition, the Board has been working closely with Senator McGuire on his bill, SB 1174. This bill would add to the Board's priorities, repeated acts of clearly excessive prescribing, furnishing, or administering psychotropic medications to children without a good faith prior exam and medical reason. This bill would require the Board to confidentially collect and analyze data submitted by DHCS and DSS, related to physicians prescribing psychotropic medications to children. The data that will be required to be submitted to the Board pursuant to this bill will ensure that the Board can review prescribing data on an on-going basis to help identify physicians who may be inappropriately prescribing. The data the Board has received under the existing DUA is only a snapshot in time, for a six-month time period in 2014. Any information that can help the Board identify inappropriate prescribing can be utilized as a tool for the Board to use in its complaint and investigation process. Once a possible inappropriate prescriber is identified, the Board will still have to go through its normal complaint and investigation process. The Board believes this bill responds to the draft audit recommendations to the Legislature.

The Board would like to respond to the recommended steps the draft report suggests that the Board should take:

Recommendation: Within 60 days, obtain and analyze the data from DHCS and DSS to identify physicians who may have inappropriately prescribed psychotropic medications for foster children.

Response: The Board does plan on having the Board's consultant analyze the additional data that has been requested from DHCS and DSS as soon as it is received. The Board will commit to requiring the Board's consultant to perform an analysis of the data within 60 days of receipt.

2005 Evergreen Street, Suite 1200, Sacramento, CA 95815-2389 (916) 263-2389 Fax (916) 263-2387 www.mbc.ca.gov

Elaine M. Howle
June 6, 2016
Page 2

Recommendation: Following the completion of its analysis, take the appropriate follow-up actions, including the investigation of physicians identified in its data analysis, that it deems necessary.

Response: Once the Board's consultant identifies physicians that need further review, the Board will begin its complaint and investigation process. The first step will involve asking assistance from DSS, as the data provided to the Board does not include names of foster children. Per the DUA, DSS will provide technical assistance, which includes, but is not limited to, facilitating contact with county child welfare agencies, the juvenile courts, county counsel, children's attorneys and other relevant entities to assist the Board in securing a court order authorizing it to obtain child-specific information, including relevant medical records. Once the child-specific medical records are obtained, the Board will follow its normal complaint and investigation process, which is confidential.

Recommendation: To the extent that its analysis is able to identify physicians who may have inappropriately prescribed psychotropic medications to foster children, the Medical Board should enter into an agreement with DHCS and DSS within six months of completing its initial review to periodically obtain the data necessary to perform the same or similar analysis.

Response: If SB 1174 passes and is signed into law, similar prescribing data will be provided to the Board on an on-going basis. If SB 1174 is not signed into law, the Board will work with DHCS and DSS to revise the existing DUA to ensure that the Board receives the most current data and that the Board receives this data on an on-going basis. However, this revised DUA will have to be agreed upon by all parties involved.

The Board greatly appreciates the opportunity to respond to the draft report and its recommendations. The Board takes the recommendations in the draft report very seriously and believes that the issues raised are very important, as consumer protection is the Board's primary mission. If you have any questions regarding this response, please contact me at (916) 263-2389.

Sincerely,

Kimberly Kirchmeyer
Executive Director

cc: Alexis Podesta, Acting Secretary, Business, Consumer Services and Housing Agency
Awet Kidane, Director, Department of Consumer Affairs

County of Los Angeles
DEPARTMENT OF CHILDREN AND FAMILY SERVICES

425 Shatto Place, Los Angeles, California 90020
(213) 351-5602

PHILIP L. BROWNING
Director

BRANDON NICHOLS
Chief Deputy Director

June 8, 2016

Ms. Elaine Howle, CPA*
State Auditor
621 Capitol Mall, Suite 1200
Sacramento, CA 95814

Dear Ms. Howle:

DRAFT REPORT – AUDIT OF CALIFORNIA'S OVERSIGHT OF PSYCHOTROPIC MEDICATIONS

Thank you for allowing Los Angeles County the opportunity to review your redacted draft report on the audit of California's oversight of psychotropic medications prescribed to children in foster care as requested by the Joint Legislative Audit Committee. Given the nature of redacted drafts, we were unable to review the report in its entirety; hence, our comments are confined to the content that was generally specific to Los Angeles.

Los Angeles County agrees with the four recommendations made in the report:

- ***Counties should implement procedures to more closely monitor requests for authorizations for psychotropic medications for foster children that exceed state guidelines for multiple prescriptions or excessive dosages.***

  Our Juvenile Court Mental Health Services agrees that they have not always, until this point, systematically monitored those proposed maximum dosage requests when reviewing requests for Psychotropic Medication Authorization prior to the court's ruling. Based on observations shared by the auditors during their review of our cases, Juvenile Court Mental Health Services agreed to always consider and give significant weight to the maximum dosage information in their review of proposed Psychotropic Medication Authorization requests and has been doing so since it was brought to their attention approximately three months ago.

- ***Ensure that prescribing physicians follow up within 30 days with all foster children to whom they prescribed new psychotropic medications.***

  Los Angeles County agrees that all youth prescribed psychotropic medications should have follow up appointments with the prescriber within 30 days and we strive to do so for all foster youth. Los Angeles County has limited authority regarding the scheduling practices of state licensed physicians and is unable to mandate prescribers to follow up with their patients within 30 days. Although we believe that the vast number of prescribers intend to follow up with foster youth within 30 days, we are aware that there are several barriers that can prevent this from occurring. Additionally, there are a limited number of credentialed prescribers who accept

* California State Auditor's comments begin on page 115.

Medi-Cal in Los Angeles County and demand for those services often exceeds capacity.

We will increase surveillance efforts by child welfare in an attempt to prioritize these youth within the healthcare system in hopes that the number of youth with no follow-up psychiatry services will be reduced.

- **Implement a process to ensure that foster children receive any needed mental health, psychosocial, behavioral health or substance abuse services before and concurrently with receiving psychotropic medications.**

① We recommend that the language of this recommendation be changed to: "Implement a process to ensure that foster children receive clinically indicated mental health, psychosocial, behavioral health, or substance abuse services associated with receiving psychotropic medications."

② We believe that this language would avoid creating a situation whereby foster children's access to appropriate care would be compromised. For example, your report indicated on page 43 that "randomized controlled trials suggest that medication management for Attention Deficit Hyperactivity Disorder (ADHD) is the first-line treatment, while medication combined with behavioral treatment may be necessary for optimal outcomes in children with more complex problems". This statement recognizes the value of individualized treatment planning based on empirical data, while continuing to support the value of psychosocial interventions in addition to medication for the majority of foster youth.

③ As to the specific findings of this report, we would like to remind the State that there was no available data regarding psychosocial interventions that were not billed to Medi-Cal prior to and that occurred in association with psychotropic medication use. This absence of data would lead the reader to assume that fewer youth received psychosocial interventions than actually did when in fact, many youth access psychosocial interventions through their schools, private insurance, contracted group homes, foster family agencies and Wraparound agencies that may not have billed their services to Medi-Cal.

- ***Implement a systemic process for ensuring that court authorizations or parental consents are obtained and documented before foster children receive psychotropic medications and that court authorizations for psychotropic medications are renewed within 180 days as required.***

We believe that several strategies need to be implemented to address this recommendation.

In order to improve the rates in which Los Angeles County's foster youth receive renewed consent by the court for psychotropic medication within 180 days, we created an electronic alert system that began on April 1, 2016. This system notifies the youth's social worker and public health nurse on the first day of the month in which the current psychotropic medication authorization is due to expire. If information regarding an updated psychotropic medication authorization is not entered into the Child Welfare Services/Case Management System (CWS/CMS), the social worker and public health nurse will receive a second reminder. DCFS continues to provide training to all caregivers which explains and clarifies the need for court authorization for psychotropic medications prior to administering the medications. The Los Angeles County contracts with foster family agencies and group homes specify that the

contracted agencies must maintain current psychotropic medication authorization for all youth on psychotropics in their care. Failure to comply with this contractual obligation results in corrective action plans with the violating contractor. However, strictly local efforts are limited in their ability to comprehensively address these issues.

This is an area in which State intervention would be helpful. Los Angeles County feels that the issue of youth receiving psychotropic medications prior to authorization by the court could most effectively be addressed at the pharmacy level. Youth are receiving medications prior to consent for treatment because prescribers are writing prescriptions prior to obtaining the court's consent despite clear directives not to do so. Caregivers then fill the prescriptions prior to the court's approval despite clear directives not to do so. Los Angeles County recommends that ④
the State create an electronic Psychotropic Medication Authorization system and link it to the Medi-Cal authorization process so that pharmacies are not approved to fill prescriptions for psychotropics that have not been approved by the court. We believe that this is the best way to ensure that no youth is administered psychotropic medication without parental or court consent.

Los Angeles County also suggests that the State, as part of its redesign of the CWS/CMS ⑤
electronic data system, allow for greater interoperability with other data systems that store health information for the youth we serve. Given the prevalence of electronic record keeping in the medical disciplines, we feel that the opportunity to collect more accurate and timely health information from providers who treat foster youth would effectively address this report's concerns regarding the lack of information in foster youth's Health and Education Passport. Although we welcome the suggestion that Los Angeles County needs more Public Health ⑥
Nurses to collect and manage this information, we also value their ability to manage the foster youth's medical needs. It would be significantly more efficient if child welfare agencies receive updated health care information on a flow basis regarding the youth we serve so that our Public Health Nurses can focus their unique skills to help our Children's Social Worker staff to interpret the information and follow up on medical needs appropriately.

Thank you for the opportunity to respond to your thoughtful report. If you have any questions, please call me or your staff may contact Lisa Sorensen, Division Chief at (213) 351-5724.

Sincerely,

PHILIP L. BROWNING
Director

PLB:HB:ls

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Comments

CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM LOS ANGELES COUNTY

To provide clarity and perspective, we are commenting on Los Angeles County's response to the audit. The numbers below correspond to the numbers we have placed in the margin of its response.

Although we appreciate Los Angeles County's suggested wording change, we believe that it does not differ substantially from the current wording of our recommendation. ①

The page numbers on Los Angeles County's redacted draft copy of the audit report do not correspond to the page numbers of the final audit report. The content Los Angeles County refers to appears on page 38 of our final report. ②

Los Angeles County appears to restate one of the key points from Chapter 2 of our report; namely, certain psychosocial services provided to foster children are not included in the State's information, including the Health and Education Passports. As we mention on page 55 of our report, all 80 of the Health and Education Passports we reviewed were missing information about the corresponding psychosocial services foster children should have received for at least one psychotropic medication. Furthermore, Figure 4 on page 56 summarizes the process for providing updated information, including psychosocial services, for the Child Welfare Services/ Case Management System operated by the California Department of Social Services (Social Services) and the resulting Health and Education Passports. A key source of that updated information is the health care provider, regardless of where that provider works. In fact, state law states that caregivers are responsible for obtaining and maintaining accurate and thorough information from physicians to be included as part of Health and Education Passports. Therefore, Los Angeles County's statement underscores the need for counties to ensure that caregivers and county staff are properly updating Health and Education Passports with mental health information to give counties a more accurate and up-to-date picture of foster children's mental health treatments. ③

We appreciate Los Angeles County's acknowledgement of the concern regarding unauthorized psychotropic medications for foster children and its idea for a longer-term solution, a concern that can be included as part of the discussions during the collaboration between Social Services and the counties as we recommend in Chapter 2. However, because it is not yet clear whether or when such a solution may be implemented, counties ④

need to take steps in the near term to better ensure that foster children receive appropriate court authorizations or parental consents for their psychotropic medications, as we recommend on page 49.

5 We appreciate Los Angeles County's acknowledgement of the concern regarding weaknesses in Social Services' data system and its idea for a longer-term solution. We anticipate that Los Angeles County can include this longer-term solution as part of the discussions during the collaboration between Social Services and the counties as we recommend in Chapter 2.

6 Los Angeles County appears to not fully understand our point regarding public health nurses. We agree fully that public health nurses should focus their unique skills on more pressing duties and not on entering data into Social Services' data system. That is why we point out on page 59 of our report that the federal government will cover 75 percent of the costs for necessary support staff for skilled professional medical personnel like public health nurses. These support staff could enter information into the Health and Education Passports, freeing public health nurses to oversee the support staff's work and to perform other, more pressing responsibilities.

JAY E. ORR
COUNTY EXECUTIVE OFFICER

COUNTY OF RIVERSIDE
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Elaine M. Howle*
California State Auditor
621 Capitol Mall, Suite 1200
Sacramento, CA 95814

June 2, 2016

Dear Ms. Howle,

Thank you for your thorough and insightful examination into the oversight of psychotropic medicine prescribed to children in foster care. Riverside County welcomes the opportunity to improve on our services to this very vulnerable and important population. We appreciate the time and attention you have given to our county in pursuit of quality improvement. Below is our response to your report for your consideration.

Counties

Recommendation: Implement procedures to more closely monitor requests for authorizations for psychotropic medications for foster children that exceed the state guidelines for multiple prescriptions or excessive dosages. When requests for authorizations exceed the state guidelines, counties should follow-up with providers about the medical necessity of the prescriptions and should document their follow-up in the foster children's case files. In instances in which counties do not believe that a provider has adequate justification for exceeding the state guidelines, counties should relay their concerns and related recommendations to the court or parent.

Riverside County Response: Agree with recommendation. To ensure that the recommendation is met, Riverside County staff will immediately review existing policies and protocols related to requests for authorization that exceed the state guidelines as well as communication of concerns surrounding the prescriptions and dosages to the court and the parent. Protocols will be updated to address these issues.

Recommendation: Ensure that prescribing physicians follow up within 30 days with all foster children to whom they prescribed new psychotropic medications.

Riverside County Response: Agree with recommendation. Riverside County supports the guidelines that prescribing physicians follow up within 30-day for all newly prescribed medications, and it is done whenever possible and as appropriate. The lack of available psychiatrists in the workforce is the largest barrier. Riverside County is already aggressively pursuing child psychiatrists to fill vacancies.

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* California State Auditor's comments begin on page 121.

The County is looking at a variety of recruitment strategies and service delivery models to more consistently meet the 30 day standard.

Recommendation: Implement a process to ensure that foster children receive any needed mental health, psychosocial, behavioral health, or substance abuse services before and concurrently with receiving psychotropic medications.

Riverside County Response: Agree with recommendation. Riverside County believes in attempting to provide non-medical interventions prior to, during and/or after medications are begun. The County
① further recommends that the Audit team consider including Rehabilitation and Case Management services as services that also meets this recommendation. Additionally, it is important to note that
② there are many behavioral health services provided to foster youth that are invisible to the County and to the State. Examples are those provided through private insurance or services at a Group Home.

Recommendation: Implement a systemic process for ensuring that court authorizations or parental consents are obtained and documented before foster children receive psychotropic medications and that court authorizations for psychotropic medications are renewed with 180 days as required. The process should also ensure that the counties better document these authorizations in the foster children's case files.

Riverside County Response: Agree with Recommendation. Riverside County has recently adopted a new process for this purpose. The County will re-examine the process to ensure it supports the recommended guidelines.

Develop and implement a process for county staff and caregivers to work together to ensure the psychotropic medications are approved before administering medications. This process should also ensure that the counties obtain accurate medication start dates from the caregivers.

Riverside County Response: Agree with Recommendation. Many of the elements of this recommendation are in place in Riverside County, much of it performed by the Public Health nurses in the program. Social Services and Behavioral Health also meet twice monthly to discuss operations. Communication with providers and caregivers is a topic they address.

Riverside County:

Recommendation: Immediately adopt the state guidelines for its physicians use when prescribing psychotropic medications and county's review of court authorization requests.

Riverside County response: Agree with Recommendation. Our County is committed to adopting the state guidelines for the use of psychotropic medications in foster youth. As we respect the need for immediacy, our county will immediately distribute the guidelines to all prescribers and instruct them to use them in their practice.

Further training for psychiatrists regarding the guidelines, development of concrete protocols, and full implementation of these processes will follow. Moreover, the Riverside University Health System – Behavioral Health will be adopting an internal data driven program improvement plan to monitor the prescriptions of psychotropic medication to foster youth.

Recommendation: Continue to use its new tracking process to better ensure that court authorizations are renewed within 180 days.

Riverside County response: Agree with Recommendation. Riverside County will continue to use the new tracking system to better ensure that court authorizations are renewed within 180 days.

Also, for consideration, Riverside County would like to highlight a few of the important improvements made for treatment services to foster youth in the past year:

- Increase in mental health services to foster youth by 34.8% from fiscal year 13/14 to fiscal year 14/15, including Trauma Focused Cognitive Behavioral Therapy.
- Services provided to foster youth which fall outside of the auditor's definition of mental health services including: Intensive Care Coordination, In Home Based Services, assessments, unbilled services provided by group home providers or foster family agencies, Wraparound services, and broad based services to families. ③
- Implementation of an extensive joint Child Welfare and Behavioral Health data tracking system.
- Analysis of barriers to recruitment and retention of child psychiatrists including the competition with the private sector. Resultant activities include an innovative partnership with the University of California at Riverside medical school and planned implementation of telemedicine practices.

The above enhancements to our system of care will serve to further our success as we fully implement the state guidelines for the prescription of psychotropic medication to foster youth.

Thank you again for the opportunity to respond to the audit.

Sincerely,

Steve Steinberg
Director, RUHS-Behavioral Health

Susan von Zabern
Director, DPSS

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Comments

CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM RIVERSIDE COUNTY

To provide clarity and perspective, we are commenting on Riverside County's response to the audit. The numbers below correspond to the numbers we have placed in the margin of its response.

Riverside County recommends in its response that we include *rehabilitation* and *case management services* as services that also meet our recommendation regarding the provision of psychosocial services before or concurrent with foster children receiving psychotropic medications. We, in fact, included psychosocial rehabilitation in our analysis. As we mention on page 41 of our report, we based this analysis on the definition of psychosocial services contained in the Healthcare Effectiveness Data and Information Set (HEDIS), a set of health care performance measures used by more than 90 percent of the health care plans in the United States. Although the HEDIS definition includes psychosocial rehabilitation, it does not include case management. We therefore stand by our methodology and the results we present in our report. ①

Riverside County appears to restate one of the key points from Chapter 2 of our report; namely, some quantities of psychosocial services provided to foster children are invisible to the county and the State. As we mention on page 55 of our report, all 80 Health and Education Passports we reviewed were missing information about the corresponding psychosocial services foster children should have received for at least one psychotropic medication. Furthermore, Figure 4 on page 56 summarizes the process for providing updated information, including psychosocial services, for the Child Welfare Services/Case Management System operated by the California Department of Social Services and the resulting Health and Education Passports. A key source of that updated information is the health care provider, regardless of where that provider works. In fact, state law states that caregivers are responsible for obtaining and maintaining accurate and thorough information from physicians to be included as part of Health and Education Passports. Therefore, Riverside County's statement underscores the need for counties to ensure that caregivers and county staff are properly updating Health and Education Passports with mental health information to give counties a more accurate and up-to-date picture of foster children's mental health treatments. ②

Riverside County states that certain types of services fell outside our definition of psychosocial services. As we mentioned earlier under Comment #1, we analyzed those types of psychosocial services included within the HEDIS definition. We included within our analysis any HEDIS psychosocial service regardless of the source—whether provided by group homes, foster family agencies, or other provider types—when we saw evidence of those services in the county's or the State's records. Furthermore, we did not include services such as intensive care coordination and assessments within our analysis because they are not mentioned in the HEDIS definition of psychosocial services. We therefore stand by our methodology and the results we present in the report. ③

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June 6, 2016

To the State Auditor:*

On behalf of the County of Sonoma Human Services Department, Health Services Department and the Probation Department, attached is the response to the recent draft of the State Auditor report on California's Foster Care System received on May 31, 2016.

We're happy to answer any questions or comments you might have. Please contact us at any time.

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* California State Auditor's comments begin on page 129.

The County of Sonoma's Response to the California State Auditor Report on California's Foster Care System*

The County of Sonoma appreciates the opportunity to respond to the draft of the State Auditor report on California's Foster Care System received on May 31, 2016.

The County was asked to respond to both the report's statewide recommendations as well as those specific to Sonoma County. These responses can be found in the pages that follow this introduction.

INTRODUCTION

Sonoma County is dedicated to protecting and promoting the safety, health and well-being of children and teens in foster care. The County continues to develop and implement high-quality, responsive programs that support foster youth. This vulnerable population can enter the foster care system for many reasons, including physical or sexual abuse in the home, neglect, abandonment, or mental health needs that are beyond the ability of caregivers to properly manage. Youth in the Juvenile Probation system may also be placed in out-of-home care. Due to their experiences and the subsequent trauma those experiences generate, these youth often need significant mental health support and treatment. Providing effective services to these youth is a primary concern in Sonoma County and statewide.

In 2013, two years prior to the Auditors' visit, Sonoma County identified that data showed higher numbers of local foster children authorized to take psychotropic medications than the statewide average. Addressing that issue became a high priority, as reflected the County's 2014-19 System Improvement Plan (SIP). Since then, the County has made system-wide changes to ensure that foster youth receive clinically appropriate psychotropic medication. Among these changes, in July 2015, the Sonoma County Human Services Department used prioritized funding to contract with an independent psychiatrist who reviews the recommendations of the treating psychiatrist prior to the social worker seeking court authorization for administration of psychotropic medication. It has been the County's intent to add this review to cases in which the court has delegated the authority to consent to psychotropic medication to the child's parent.

As another example, ongoing training for social work staff regarding best practices for psychotropic medications, side effects and options treatment continues. Two areas of focus also include how to clearly and effectively communicate with prescribing physicians and with foster youth regarding their experience with those medications and their use and monitoring for potential side effects. Sonoma County is proud of the services it provides to foster youth, including necessary mental health treatment. Nonetheless, it welcomes outside reviews and input on ways to improve. The County intends to implement all the recommendations of the State Auditor, as discussed more fully below. At the same time, the County takes issue with some of the narrative in the audit report, and would like to address those before turning to the recommendations.

* California State Auditor's comments begin on page 129.

The audit report has underscored the need for a high-level of detail in documentation. Systematic and consistent documentation is important to monitor and evaluate data, as noted in the audit report, and Sonoma County has focused on improving this since 2014. Sonoma County acknowledges the deficiencies in documentation described in the audit report and is working to improve its documentation.

However, as the audit report notes, missing information does not mean that, in fact, foster children were taking psychotropic medications in excessive doses or multiple medications in the same category. Mental health treatment information is maintained by the treatment provider, and in order to understand the treatment received by an individual foster youth, one must review the actual mental health treatment record. We are concerned that many of the cases referred to in the report did not reference the actual treatment decisions of the providers and the data for the audit was based less on chart review and more on claims data. ① ②

In addition, these medications can only be prescribed to foster youth by medical professionals who have standards to which they must adhere. Furthermore, the judicial system provides oversight, including providing these foster youth with legal counsel, who meet frequently with the youth and advocate on behalf of their client's best interests.

We are confident that if the auditors had an opportunity to look deeper into each child's records, they would have found that Sonoma County foster youth receive clinically appropriate amounts and types of psychotropic medication. ① ②

The audit report also gives the incorrect impression that Sonoma County foster youth are not provided non-pharmacological interventions. This is untrue. Foster youth are provided mental health, substance and other alternative services to pharmacological interventions before and/or concurrent with the prescription of psychotropic medication as clinically indicated. This information is often documented in contract, authorization and payments systems of the Human Services Department. The audit report findings do not take these documentation realities into account. Information is also required to be kept by licensed residential treatment providers and individual private practice psychiatrists. An audit of these records would have supplemented the audit report with additional specific information. ① ① ②

In addition, the audit report gives the false impression that Sonoma County does not follow generally accepted professional standards when prescribing psychoactive medication to foster care youth. In fact Sonoma County prescribers (who treat serious and severe mental illnesses through the County Mental Health Plan to youth in and outside the foster care system), are bound by and adhere to the prescribing standards established by federal and state law governing county mental health plans. As the audit report points out, Sonoma County's policies were in need of updating, and the County has made those updates. County policies now incorporate the most current version of the Los Angeles Department of Mental Health, Parameters 3.8, for Use of Psychotropic Medication in Children and Adolescents and the *California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care* (including appendices A-D). If the recommended prescribing guidelines are not met, or if medications ③ ④ ⑤

are prescribed outside the recommended parameters, the prescribers will be urged to seek peer consultation and/or clinical review with the Sonoma County Behavioral Health Medical Director.

Finally, the County has some questions and suggestions about the methodology of the report. First, it
6 would have been helpful to have a clear breakdown between the departments involved with foster youth: Family, Youth and Children's Services Division and Probation. Children in each of these areas have differing needs for mental health interventions and care. A further description of the methodology in general and case review selection process would help the County understand how these cases relate to the child welfare population taking psychotropic medications, as well as the general child welfare population as a whole. In addition, the data reporting would be enhanced by hypothesis and proportions testing.

We note also that some statewide and Sonoma County recommendations, such as those calling for better documentation, are similar, which reinforces our belief that many issues highlighted in the report
7 affect counties across the state. We hope that the State will offer additional guidance and resources to all counties to enhance consistency and clarity of implementation of these recommendations.

Therefore, with some caveats, Sonoma County finds the audit report recommendations for 1) all counties statewide and 2) Sonoma County are reasonable and constructive measures that will advance our mission of promoting the well-being of foster children in our care.

RESPONSE TO THE STATEWIDE RECOMMENDATIONS:

Recommendation 1. Implement procedures to more closely monitor requests for authorizations for psychotropic medications for foster children that exceed the state guidelines for multiple prescriptions or excessive dosages. When request for authorizations exceed the state guidelines, counties should follow-up with providers about the medical necessity of the prescriptions and should document their follow-up in the foster children's case files. In instances in which counties do not believe that a provider has adequate justification for exceeding the state guidelines, counties should relay their concerns and related recommendations to the court or parent.

RESPONSE: Sonoma County supports this recommendation.

Recommendation 2. Ensure that prescribing physicians follow up within 30 days with all foster children to whom they prescribed new psychotropic medications.

RESPONSE: Sonoma County supports this recommendation.

Recommendation 3. Implement a process to ensure that foster children receive any needed mental health, psychosocial, behavioral health, or substance abuse services before and concurrently with receiving psychotropic medications.

RESPONSE: Sonoma County already ensures that foster children receive these services before or concurrently with medication, but will work on putting systems in place that better track and document these services, and therefore Sonoma County supports the recommendation. (8)

Recommendation 4. Implement a systemic process for ensuring that court authorizations or parental consents are obtained and documented before foster children receive psychotropic medications and that court authorizations for psychotropic medications are renewed within 180 days as required. The process should also ensure that the counties better document these authorizations in the foster children's case files.

RESPONSE: Sonoma County supports the recommendation.

Recommendation 5. Develop and implement a process for county staff and caregivers to work together to ensure that psychotropic medications are approved before administering medications. This process should also ensure that the counties obtain accurate medication start dates from caregivers.

RESPONSE: Sonoma County supports the recommendation.

RESPONSE TO THE SONOMA COUNTY RECOMMENDATIONS

Recommendation I. Immediately adopt the state guidelines for its physicians' use when prescribing psychotropic medications and the county's review of court authorization requests.

RESPONSE: Sonoma County supports this recommendation. The County was aware of a need to update policies around psychotropic medication before the auditors began their review and have been working on those updates. We have already completed the policy revision necessary to adopt the current state guidelines (5)

for physicians' use when prescribing psychotropic medications and for review of court authorization requests.

Recommendation 2. Within six months, implement a process to review psychotropic medications that parents, rather than courts, are able to approve for children.

RESPONSE: Sonoma County supports the recommendation.

Recommendation 3. Update its policies to describe an acceptable method for obtaining and documenting parental consent for psychotropic medications.

RESPONSE: Sonoma County supports the recommendation.

Comments

CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM SONOMA COUNTY

To provide clarity and perspective, we are commenting on Sonoma County's response to the audit. The numbers below correspond to the numbers we have placed in the margin of its response.

Sonoma County apparently misunderstands the scope of our audit. Namely, we were directed to examine state and county oversight of psychotropic medications prescribed to foster children, as we state on page 15 of our report. As such and contrary to its statement, we did not need to review provider health records or charts for each foster child to understand the treatment received by individual foster children nor to determine whether each foster child received clinically appropriate amounts and types of psychotropic medication. Rather, to review Sonoma County's oversight we examined its records, and when necessary, records maintained by relevant state oversight agencies. We did this to understand, analyze, and assess the processes Sonoma County used to oversee such prescriptions, including whether and how Sonoma County ensured that foster children under its charge received psychosocial services in advance of or concurrent with their prescribed psychotropic medications as recommended by relevant guidelines. We stand by the methodology and the results we present in our report. ①

As we stated in the previous comment, we stand by the methodology we used and the results attained by our implementation of that methodology. To identify information relevant to the audit, we examined available records at Sonoma County, such as documents from foster children's welfare case files and behavioral health files. We also examined records within certain of the State's data systems, including the Paid Claims and Encounters System operated by the Department of Health Care Services (Health Care Services) for each foster child. Contrary to Sonoma County's assertion, reviewing provider records or charts for each foster child was not only unnecessary, it was not within the scope of our audit. Furthermore, we provided Sonoma County opportunities during our audit to provide additional records for every potential Sonoma County exception we identified. ②

Finally, as we indicate on page 21 of our report, we understand that medically appropriate reasons may exist to explain why a provider requests psychotropic medications for foster children in amounts and dosages that exceed the state guidelines. However, if counties do not follow up with providers to obtain assurance that such instances are medically appropriate, counties miss opportunities to better protect their foster children from inappropriate psychotropic medication prescriptions.

③ Sonoma County is incorrect; we do not state, nor do we imply, that it does not follow generally accepted professional standards when prescribing psychoactive medication to foster children. The methodology we followed enabled us to examine Sonoma County's oversight to determine whether it was ensuring whether provider's prescribed psychotropic medications were within academy and state guidelines and whether it reasonably questioned those prescribers when they prescribed psychotropic medications outside these guidelines. As we mention on pages 14 and 15 of our report, the California Department of Social Services (Social Services) and Health Care Services stated that the prescribing standards within the state guidelines are current best practices, and that they serve as a foundation for review to ensure that children receive the appropriate amounts and dosages of psychotropic medications. The academy and state guidelines are appropriate yardsticks to use for our analysis of the counties, and we stand by our conclusion that we often found little indication that counties followed up with providers to ensure the appropriateness of psychotropic medications prescribed in excess of the state guidelines.

④ Sonoma County's statement that its providers "are bound by and adhere to the prescribing standards established by federal and state law governing mental health plans" is irrelevant to this audit; we did not assess such compliance. As stated in earlier comments, the scope of our audit was to examine the State and county oversight of psychotropic medications prescribed to foster children. Furthermore, as we mention on pages 14 and 15, Social Services and Health Care Services stated that their prescribing standards are current best practices, and that they serve as a foundation for review to ensure that children receive the appropriate amounts and dosages of psychotropic medications. The academy and state guidelines are appropriate yardsticks to use for our analysis of the counties, and we stand by our conclusion that we often found little indication that counties followed up with providers to ensure the appropriateness of psychotropic medications prescribed in excess of the state guidelines.

⑤ Sonoma County only recently adopted the state guidelines. Sonoma County informed us on June 3, 2016, that it had adopted the state guidelines the previous day.

⑥ We acknowledge Sonoma County's statement that children entering foster care through the child welfare system may have different mental health needs than children entering through the probation system. However, this point is not relevant for purposes of our audit. The methodology we used to assess Sonoma County's oversight of psychotropic medications prescribed to foster children and its adherence to relevant academy and state guidelines is applicable to children entering foster care through either system.

Implementation of the recommendations we make to Social Services beginning on page 74 of our report should address Sonoma County's comment regarding additional guidance and resources from the State. We recommended that Social Services collaborate with counties and other relevant stakeholders to develop and implement a reasonable oversight structure. (7)

Despite its assertion that Sonoma County already ensures that foster children receive psychosocial services before or concurrently with psychotropic medications, our audit demonstrates that Sonoma County's records cannot provide such assurance. As we show in Table 11 on page 39 of our report, Sonoma County was unable to provide evidence showing that some of the foster children whose case files we reviewed had received corresponding psychosocial services in the six months before starting at least one psychotropic medication. We look forward to reviewing Sonoma County's future updates on the implementation of our recommendation and its efforts to put systems in place to better track and document these services. (8)