

Psychotropic Medications Podcast  
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**Kelly Meehleib:** Welcome to the Judicial Council's Center for Families, Children, in the Courts podcast series on Juvenile Law. Today we are joined by Bill Grimm, Directing Attorney for Child Welfare from the National Center for Youth Law (NYCL). Bill joined NYCL in 1988 and has been lead counsel for the Center's class action foster care reform litigation in Arkansas, Utah, Washington, and Clark County, Nevada. Bill is widely recognized as one of the country's leading experts on the issues facing children in foster care and is at the forefront of California's efforts to change policies and laws around the administration of psychotropic medications for children in care. Welcome, Bill.

**Bill Grimm:** Glad to be here.

**Kelly Meehleib:** I'd like to start at the beginning. What was the issue or issues that you were seeing in California around the prescription of psychotropic medications for children in foster care?

**Bill Grim:** Well, in 2011 Congress amended federal law to require that all the states develop protocols for the appropriate use and monitoring of psychotropic medications administered to children in foster care. When that law was enacted in 2011, there was little data out there about the drugs being prescribed and given to children in our foster care system. Second, unlike most other states, California's system placed authority for authorizing psychotropic medications with the courts, was to protect children from inappropriate and harmful medications. But, we also did not know to what extent the courts were ensuring informed decisions were being made on the drugs given to children in foster care. Congress, after, California rather, after the enactment of the 2011 federal law responded pretty quickly to develop clinical guidelines and promote data sharing across agencies, including the California Department of Social Services and California Department of Health Care Services.

**Kelly Meehleib:** How did you identify the issues?

**Bill Grimm:** Well, since there really wasn't a whole lot of data already out there, our office along with several senators in the California Legislature filed the Public Record Act Request with the California Department of Social Services and Department of Health Care Services. This led to a data sharing and matching of data between the what the California Department of Social Services had about children in foster care and what the Department of Health Care Services had concerning the Medicaid claims, including claims for medications that were paid on behalf of foster children. And as a result of that data sharing and data matching, for the first time we really began to have a fairly good picture of the prescribing practices and the drug, psychotropic drugs that were being given to children in foster care.

**Kelly Meehleib:** Okay. And so, what has California done to address the issues?

**Bill Grimm:** Well, I think it's fair to say that California is far ahead of many if not most states in its response to this particular issue. The California state auditor in 2016 conducted a study of what was happening in terms of psychotropic medications being provided to children in foster care. California established clinical guidelines and data sharing practices. Those were developed and then adopted by the Department of Health Care Services and CDSS. There were three legislative hearings in 2015 and 2016, really resulting in a multi-faceted approach to improving the decision-making and oversight. Things such as increasing the authority and resources for public health nurses, requiring inspections of group facilities that were suspected of over medicating children in foster care, improved training for caseworkers and others, and improving the information provided to the court who is making decisions about whether to authorize or not psychotropic meds for children in foster care. Legislature in California also appropriated additional funds to expand the number of public health nurses in California and last session appropriated funds to provide a psychiatric consultant to the counties to provide a second opinion for them when there were concerns about the psychotropic medications being prescribed for children in foster care.

**Kelly Meehleib:** Okay. And can you talk about the process in California for authorizing psychotropic medications for children in foster care?

**Bill Grimm:** The processes here is fairly unique in the country. Since 1999, the juvenile court has been responsible, has had the authority to authorize psychotropic medications for children in foster care. There are not many states in the country where the courts are the decision-maker. Our office, actually, is now involved in a federal class action in the state of Missouri where we are challenging the lack of procedural safeguards on the decision to prescribe and administer psychotropic meds. In Missouri, it's the caseworker who is allowed to make that decision and consent to medications and some instances isn't even the foster care giver is the consentor. That's never, that's not been the case in California since 1999.

Also, what has happened as a result of the reform efforts by the judiciary is that new forms and rules have been adopted to govern the applications made to the court for the approval of psychotropic medications. Among other things, these forms expand the information that the prescriber is expected to provide and support the application filed with the court. Also, with recent changes in the rules and forms, the child, the child's caregiver, CASA, and others now can provide the court with their own views and opinions about how the child is responding to the medication that they're being administered. So, our process that was in place since 1999, has result of both legislative and rule changing, things happening as Judicial Council, been modified, I think, in a way that really improves the overall court authorization process.

**Kelly Meehleib:** So, besides the court authorization process, what other roles does the court have in the process?

**Bill Grimm:** Well, I think and, and Judge Borack, who was on the panel with me this afternoon, agrees, I think, with this. The real job of the juvenile court judge is to act as a reasonable and prudent parent when reviewing the decision or reviewing the application for authorization of psychotropic medications. And what this requires is that the court has to ask the same kinds of questions that a reasonable parent would ask when a child is being placed on what are very powerful, mind-altering medications. The court has to have, I think, has to come to this with the perspective that these powerful medications have both serious short-term and long-term effects, and have to take that into consideration as they evaluate and balance the risks and benefits. I think the other thing that, that Judge Borack said that I agree with as well, is that the court's not there to second-guess the doctor, but I think Judge Borack would also agree that the doctor's not infallible and it's appropriate to ask questions before making serious decision about the use of medications with children. The court has an obligation to ask questions, to review the evidence put before it, to determine whether that evidence is sufficient, to warrant the authorization of psychotropic medications, and I think the court also has an obligation to review that decision periodically. Children should not be placed on these medications indefinitely or for extended periods of time without the court looking at how the child is reacting to that.

**Kelly Meehleib:** What is the role of attorney in this process?

**Bill Grimm:** Well, the attorney for the child, of course, has the right to file an objection with the court or to file the JV 222, where they may not necessarily object, but bring to the court additional information that would help the court make an informed decision of whether or not to authorize the psychotropic medications. I think the attorney has to play a role in reviewing, thoroughly reviewing the application, determining whether the application answers the questions that form requires be answered, and explore also with their client how the child feels about the use of the medications. And particularly, where it's an application to renew the medication, there should be a conversation with the child by his or her attorney about the effects, both good and bad and adverse, concerning the medication on the child. I think that attorney has an obligation to check the accuracy and the thoroughness of the information being provided to the court.

We had an example at, again at the session this afternoon, where a public health nurse found the form signed by the physician indicated that the child was in therapy. But when the child was asked by the public health nurse in this situation, not the attorney, the child said, "I haven't been in therapy for three or four months." And, it turned out that the child's statement was accurate. And so, that information was corrected before the court.

I think the attorn-, child's attorney also has an obligation to ensure that the lab work that is a prerequisite or should be a prerequisite to administration of these medications, has been done for the child and if not, to see whether there obstacles in getting that lab work done, so that the standard of care for kids is, is met. On many of these medications, lab work like blood glucose and cholesterol levels should be checked before the child begins the medication and then periodically while the child remains on the medication so that if there is a suggestion that the child may be developing type 2 diabetes, which is unfortunately a known adverse effect of the

antipsychotic medications, that, that adverse effect is picked up early enough that appropriate responses can be made to what's happening with the child.

**Kelly Meehleib:** Thank you. And are you keeping track of any outcomes?

**Bill Grimm:** Well, part of the, of the state's quality improvement project on this, which our organization was a part from the very beginning, was to develop and adopt outcomes to look at what did, do these changes legislatively, judicially, and otherwise, are they actually changing outcomes for children?

So, some of the outcomes that were adopted included looking at what percentage of foster children are on psychotropic medications overall. Are those percentages going down? What percentage of children are on the class of drugs called antipsychotics, and is that moving up or down? What percentage of children are having the lab work done that should be done before and during the time the child's on the medication? Those are some of the outcomes that have been now adopted and you can go to the Department of Social Services website today and you can find the data on those outcomes for both the state and for each individual county broken down by age groups, by race, ethnicity, gender, type of placement. So, we have, I would, I would say now, in California, the kind of data that's being developed about these outcomes, is more extensive and more refined than any other state in the country. We're really ahead of the game in terms of the providing information that can promote a public dialogue about the use of these medications with children in foster care.

**Kelly Meehleib:** And how are we doing in California?

**Bill Grimm:** Well, I, I think, to begin with, it's kind of early in the, in the, after the adoption of these reforms to make a broad statement about how we are doing. We do know that you know in the, in the last year, there has been a decrease in the percentage of children who are on psychotropic medications and somewhat of a decrease in the use of antipsychotics. We are seeing some improvement in the percentage of children who are having the appropriate lab work done. We're nowhere near where we need to be on this. So, I think, at this stage of the reforms, there's some information that suggests that we're going in the right direction or being more careful in our use of these medications with children and that we're seeing that they're getting the kind of care that they need in terms of the follow up lab work, at least.

**Kelly Meehleib:** What are a few practical tips for the court and/or attorneys to look for when determining whether to sign an order for psychotropic medications?

**Bill Grimm:** Again, we talked about this in the workshop this afternoon. I think there are a number of key questions, key issues for the court to focus on and attorneys as well. I think the first one is to look at what does the prescriber know about the child? Is this a prescriber who has been treating the child for two or three years and based on that experience and perhaps the prior use of medication, is recommending a certain drug be given to the child? Or is this a prescriber

to whom the child was taken two days ago, has no history of the child? And then also, what did that child, what did that prescriber know about the child in terms of their past medical history, the traumas that they may have suffered? Because oftentimes traumas lead to behaviors that mimic the types of symptoms we see with mental illness or, and in this case, we don't know what the, what information the prescriber had. I think the court needs to ask and the attorneys need to ask, *What are the risks and benefits of this medication?* And, *How do we balance out those and both short and long-term risks in that assessment?*

I think one of the other key questions or red flags and all of this is, is this a request for multiple drugs? I would suggest whenever you're going to put a child on two or three medications, a red flag should go up and the burden, the evidence needed to convince the judge that that's a necessary part of the child's treatment also goes up. I think whenever the drug involved is an anti-psychotic, there should also be a heightened burden of proof in that situation. In Washington state, for example, about two years ago their legislature enacted a law that requires a second opinion any time an anti-psychotic is being prescribed to a child in foster care. We aren't there yet in California. I'm hoping someday we moved in that direction as Washington has. But at the very least the court and the attorney, for them, a red flag should go up when an antipsychotic is being prescribed, but particularly the younger of age of child. Nobody really, no child under five except in very very isolated situations should be administered an anti-psychotic medication.

And, you know, one other thing I would suggest, and this is probably hoping for too much, is that the court and the attorneys begin to be educated about what is the science to support the particular use of the medications being prescribed. Now, we've been working on this issue for four or five years and so we and we've devoted substantial resources in our office to that. So, we regularly read the monthly Journal of the Child and Adolescent Pharmacology Psychopharmacology. That journal often times publishes articles about the safety and efficacy of medications. Ideally, I would hope that there was some way we could get that information to the attorneys and the judges who are authorizing these medications so that they were doing it based upon the actual science as opposed to maybe the recommendation of a physician, in some cases even, a nurse practitioner, that a child be placed on psychotropic medications.

So, those are some of the areas of inquiry I think that are key to the judge and the attorneys playing their role in this whole decision-making process.

**Kelly Meehleib:** Well, thank you, Mr. Grimm, so much for spending time to talk with us today.

The Judicial Council's Center for Families, Children & the Courts works with courts throughout the state to improve outcomes for children and families in both the Juvenile Justice and Child Welfare systems. For more information, please visit our website at [www.courts.ca.gov](http://www.courts.ca.gov) under Programs for Families and Children.