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IN THIS ISSUE

Foster Care and Psychiatry

Learning Objectives

After reading these articles you should be able to:

1. List the challenges unique to foster care children that can contribute to psychological issues. **2.** Summarize the basic principles for medication use in foster care children. **3.** Describe some of the alternatives to medication in treating foster care children.

Foster Care and Child Psychiatry: A Primer

Glen R. Elliott, MD, PhD is the Editor-in-Chief of The Carlat Child Psychiatry Report.

Dr. Elliott has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

In this issue of *CCPR* we focus on the treatment of children in foster care systems. Nearly one in three of these children have significant psychiatric problems during their time in foster care—especially those related to trauma and neglect that brought them into the system (McMillen JC et al, *J Am Acad Child Adolesc Psychiatry* 2005;44(1):88–95). Recently, psychiatrists working with foster kids have been under fire for allegedly overusing medications, especially antipsychotics.

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In Summary

- In California, almost 1 in 4 foster children ages 12 to 17 are taking a psychotropic medication; 62% of those prescriptions are for antipsychotics.
- California prescribing guidelines encourage doctors to stick with FDA-approved medications, to keep dosages low, and to periodically wean patients off of medications to make sure they are working.
- The Governor of California just signed legislation requiring the state to train caregivers and court officials on the hazards of psychotropic drugs, to review children's health records for excessive prescriptions, and to increase scrutiny of residential facilities that appear to rely too heavily on medications to control kids' behavior.

Q&A With the Expert

The Politics of Medicating Children: Problems and Solutions

Karen de Sá
Investigative Reporter
San Jose Mercury News

Karen de Sá has disclosed that she has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

CCPR: Karen, your series "Drugging Our Kids" about medication treatment of foster children has spurred the California legislature to pass several laws designed to discourage the excessive use of psychotropics in foster children. What did your reporting reveal about psychiatric treatment in the California foster care system?

Karen de Sá: The key findings were that of the children ages 12 to 17 in the California foster care system, almost one in four were receiving a psychotropic of some kind, broadly defined. But even more surprising, 62% were receiving an antipsychotic. Recent figures from the state show that more than one-third of those prescribed psychotropics were on multiple medications.

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Foster Care and Child Psychiatry: A Primer

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The articles in this issue will help practitioners answer questions such as: When do we use medications, and why, and what other options for treatment exist? In this introductory article, I'll provide you with a brief primer on how foster care works, and how psychiatrists get involved.

What is Foster Care?

When children are in a tough home situation—whether involving abuse, neglect, or other circumstances—it's not a given that they will end up in foster care. At least 25% go into what's called "kinship care" (www.childwelfare.gov/topics/outofhome/kinship/; Winokur, M. Cochran Database System Review 2014 (1)). This means that the child goes to live with a relative or a family friend for a while, often in an informal arrangement that does not involve the courts or legal action. This is not foster care, because the child is not a "ward of the state."

Foster care typically enters the picture when an untenable home situation comes to the attention of the police or a state agency such as child protective services (Schor EL *Pediatr Clin North Am* 1988;35(6):1241–1252). Sometimes, the parents call the authorities because they are concerned for their child's well-being. Other times, someone else such as a teacher, physician, mental health worker, or neighbor reports concerns. When the situation is dire, police respond to a complaint and are dispatched to the home, often with a social worker. The child may then be taken into temporary protective custody with an organization such as a state's department of social services or children's shelter care system for 48–72 hours. After this, there is a confusing set of hearings that will vary from state to state. During these hearings, the child might be living with a temporary foster family or in a group home.

There are various reasons psychiatrists might need to know about this process. First, as a mandated reporter, you may be the one who contacts child protective services because of concerns about a child's safety. Second, you may be asked to do an evaluation over the course of the hearings to determine whether placement outside the home is in the best interest of the child. If it is decided that the child should be returned to the current home environment, you may be asked to complete a reunification readiness assessment. Third, if you end up treating the child, some of the first records you review will be reports detailing the outcomes of the hearings.

Once the child is in the legal system, there are typically three hearings. First, there is an emergency detention hearing to decide if there are enough grounds to keep the child in protective custody while a more deliberate decision-making process

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New Editor of CCPR: Glen Elliott

We're happy to welcome Glen Elliott, MD, PhD, as the new Editor-in-Chief of the Carlat Child Psychiatry Report. Dr. Elliott is a board-certified child and adolescent psychiatrist with a distinguished and varied career. His education spanned both coasts: he went to medical school at Stanford (where he also received a PhD in neuro- and biobehavioral sciences); he did his psychiatry residency at McLean Hospital in Belmont, Massachusetts; then he returned to Stanford for his fellowship in child and adolescent psychiatry. For many years, he was the Director of the Children's Center at Langley Porter Psychiatric Institute, U.C. San Francisco. He has received numerous teaching awards for his work with residents. He is currently the Chief Psychiatrist and Medical Director at Children's Health Council, a community mental health center affiliated with Stanford, as well as Associate Training Director for the Stanford Child and Adolescent Psychiatry Residency Training Program. We're thrilled that Dr. Elliott has joined the Carlat team!

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occurs. Second, a jurisdictional hearing will take place usually within 2 weeks where the judge reviews all the evidence and decides if the allegations of abuse or neglect are true. Finally, if the judge agrees with the need for custody, there is a dispositional hearing. For this hearing, a social worker prepares a "case plan" that lays out the problem and a proposed solution. Often, a psychiatrist is asked to do a diagnostic evaluation and to recommend a treatment plan. Based on this hearing, the child might be placed in one of several situations. Options include not only being placed in a foster family home (what most typically think of as foster care, basically living with strangers) but also being fostered with relatives or living in a group home or a residential care facility, the latter places differing mainly by the size of the foster population. There are also short-term emergency shelters when more permanent placement is not immediately available. The intent of the system is to place the child in the least restrictive setting compatible with good care, with the ultimate goal, when feasible, of returning the child as quickly as possible back to the parents or legal guardians.

The Foster Family

In 2013 (the most current data available), the total number of children and adolescents in foster care was just over 400,000, with 15% under age 2 and 25% between the ages of 14 through 17 (http://www.acf.hhs.gov/programs/cb/resource/afcars-report-22).

While specific rules vary across states, foster parents must have state licensure and receive training before taking responsibility for a child (www.childwelfare.gov/pubPDFs/foster.pdf). They are also screened in other ways, including age, income, suitability of housing, and absence of a criminal record. Foster parents receive reimbursement, usually a per-diem rate per child in the range of $20–$25/day, depending on the state (the amount increases if more intensive psychiatric or medical conditions exist). As a clinician, you will want to have a sense of who the child's foster family is so that you can assess the appropriateness of placement and adequacy of parenting, just as you would with any other child or adolescent.

Foster Care and Psychiatric Treatment

Foster care children can have an array of behavioral problems and specific psychiatric disorders. The process of being taken out of one's home and separated from parents and siblings is stressful, even in the absence of a specific traumatic event. Since many children are removed by child protective services because of neglect, abuse, or unsafe living situations, foster care children may have complex reactions of relief combined with guilt and feelings of abandonment. One study of foster adolescents (McMillen JC et al, *J Am Acad Child Adolesc Psychiatry* 2005;44(1):88–95) found a 32% prevalence of lifetime psychiatric disorders, and 10% of those surveyed met criteria for both an internalizing disorder such as major depression, PTSD, or mania and an externalizing disorder such as ADHD or some other disruptive behavior disorder. In this study, the best predictor of having a psychiatric disorder was the number of different types of maltreatment the individual had experienced.

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Basic Principles for Medication Use in Foster Children

- Make sure there is a larger treatment plan in place, including psychosocial approaches.
- Review as many collateral documents as you can, such as court reports, prior medical and psychiatric records, and the individualized education program (IEP).
- Identify and carefully document diagnoses and specific target symptoms.
- Consider whether existing medication therapy may be exacerbating current symptoms.
- Prioritize specific target symptoms that will be targeted by the medication (most problematic and most recent symptoms having greatest priority); set reasonable goals and make one pharmacologic intervention at a time, if possible.
- Monitor therapeutic response regularly; taper/discontinue if no benefit.
- Monitor side effects regularly; consider alternatives if a child is experiencing side effects.
- When possible, choose agents with FDA indications for pediatric use, use lowest effective doses, attempt sequential monotherapies before initiating polypharmacy, and make periodic assessments to determine whether medication is still indicated.
- Available evidence to support the use of medication in preschool-aged children is extremely limited; non-pharmacologic interventions should be tried first (Gleason MM et al, *J Am Acad Child Adolesc Psychiatry* 2007;46(12):1532–1572)
- Medications should not be used as disciplinary measures or chemical restraint, nor should they be a condition for placement of foster children.

Expert Interview

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CCPR: How does that compare to the percentage of all children in the U.S. who receive these meds?

Karen de Sá: The best comparative study we could find revealed these rates to be 3.5 times the rate of prescribing for all adolescents nationwide.

CCPR: The key question is whether they are receiving too many medications as opposed to therapy or other non-med treatments. Are there particular foster kids who are more likely to be prescribed medication?

Karen de Sá: We found the highest prescribing rates in the institutions and group homes settings. Depending on the setting, the vast majority of these kids are typically on psychotropics, according to the child welfare system's own data.

CCPR: Presumably the psychiatrists are prescribing medication to achieve some sort of therapeutic outcome, whether it's improved mood or less acting out. Does it appear that this is happening in the California system?

Karen de Sá: Certainly this is one of the main arguments for using medications for these kids, to "stabilize placement." The rationale is that without medications, they would be kicked out of one setting and end up at another, and another, and so on. We interviewed many child psychiatrists and other doctors for our series. There was a sense of frustration. These are really tough and difficult situations. When you're a kid, and you've been hurt continually and abandoned, and you're alone and scared, you don't sit down and talk to someone and say, "Well, doctor, I'm really not feeling well today, and I'm wondering if you could help me with some cognitive behavior therapy." No, you may throw a chair at somebody. You don't have the words to express things, and therefore you are either self-destructive or you are lashing out or you're terribly sad. However, the data show that doctors are turning too quickly to antipsychotics. The Office of the Inspector General recently looked at the five largest states prescribing antipsychotics to Medicaid-enrolled kids. Their findings were that in 66% of cases, there were serious quality of care concerns. More than half of the kids had been poorly monitored, 40% had received what they termed "wrong treatment," and more than 33% had received "too many drugs." (The full OIG report is available at http://oig.hhs.gov/oei/reports/oei-07-12-00320.asp.)

CCPR: That is concerning, particularly since we know that kids are especially susceptible to antipsychotic side effects.

Karen de Sá: We interviewed dozens of foster youth who had been on antipsychotics, and their stories were remarkably consistent with regard to the onset of tremors, dramatic weight gain, and sedation. The sedation, in particular, was very problematic for school performance. There is already so much concern about foster kids not doing well academically, and we found that many of the kids in our series on psychotropics were literally sleeping through school.

CCPR: How about the kids that are in a presumably more stable environment, such as a long-term foster family situation?

Karen de Sá: The lowest rates of prescribing happen when kids are placed with relatives, pre-adoptive families, or foster care parents who care for them over a long period of time. These placements were something approximating a family, with people who are invested in and care about them. In a traditional family environment, either one or both caregivers would have an established working relationship with their child's doctor. If that clinician recommended psychiatric drugs, caregivers would be doing their due diligence—checking back, making frequent visits, calling when anything came up.

CCPR: I would imagine that kids who are not in stable homes risk seeing multiple clinicians and getting bounced from doctor to doctor without someone "being in charge."

Karen de Sá: Exactly. A doctor may be responding to a desperate situation such as a foster parent who is saying, "Look, I really want to keep this kid, but I just can't. He is damaging property. He is punching out his foster siblings. I'm going to have to turn this kid back to the agency." And a sympathetic physician might say, "Alright, look, let's try this medication" but then that crisis pattern may continue in the next placement, and a different doctor adds another medication instead of peeling back, and eventually what started as an emergency intervention turns into a treatment plan with several medications and long-term side effects. What I have found interesting in my research for the series is that there are a lot of things to do to help traumatized kids that are not pharmacologically based. One of the simple things that most of these kids need is having someone to talk to; somebody they feel comfortable with and connected to, and who cares about them. Some facilities are using specific therapies to deal with the impacts of the trauma, like animal-assisted therapy and meditation. And there are the arts: martial arts, theater arts, music and art therapies.

"What [the children we interviewed] consistently said is that when they came off the medications and they found other specific things to focus on, they got better."

Karen de Sá

CCPR: In your interviews with some of the kids, did you find that they mentioned certain interventions that they found more effective for them than medications?

Karen de Sá: Absolutely. They all did. First of all, I want to acknowledge that the dozens of young people we interviewed for this project were brave and gracious enough to literally open up their child welfare files and their medical records to us. What they consistently said is that when they came off the medications and they found other specific things to focus on, they got better. For example, one girl in a group home was on so many medications she couldn't engage in talk therapy; her speech was

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Antipsychotics Potentially Used in Children

Generic (brand)	FDA indications in peds (age)	Daily dosing range *	Side effects	Monitoring
Aripiprazole (Abilify)	Schizophrenia (13+) Bipolar mania monotherapy and adjunctive (10+) Irritability in autism (6+) Tourette's disorder (6+)	2–30 mg	Sedation Agitation Akathisia Weight gain	Glucose/HbA1c Lipids Weight/BMI EPS/TD
Asenapine (Saphris)	Bipolar mania, monotherapy and adjunctive (10+)	5–20 mg	Akathisia Somnolence Weight gain	Glucose/HbA1c Lipids Weight/BMI EKG EPS/TD
Brexpiprazole (Rexulti)	Not approved for peds use	2–4 mg	Sedation Agitation Akathisia Weight gain	Glucose/HbA1c Lipids Weight/BMI EPS/TD
Chlorpromazine (Thorazine)	Severe behavioral disorders (6 months–12 years) Psychotic disorder (12+)	5–800 mg	Sedation Dry mouth Constipation Orthostasis	TD
Clozapine (Clozaril)	Not approved for peds use	6.25–600 mg	Sedation Constipation Orthostasis Tachycardia Weight gain Salivation Agranulocytosis	CBC Glucose/HbA1c Lipids Weight/BMI EKG EPS/TD
Haloperidol (Haldol)	Psychotic disorder (3+) Severe behavioral disorders (3+) Tourette's disorder (3+)	0.5–15 mg	EPS Prolactin elevation Sedation	EPS/TD Symptoms of prolactin elevation
Iloperidone (Fanapt)	Not approved for peds use	12–24 mg	Dizziness Somnolence Weight gain	Glucose/HbA1c Lipids Weight/BMI EKG EPS/TD
Lurasidone (Latuda)	Not approved for peds use	40–160 mg	Akathisia Agitation Somnolence Weight gain	Glucose/HbA1c Lipids Weight/BMI EPS/TD
Olanzapine (Zyprexa)	Schizophrenia (13+) Bipolar mania, monotherapy and adjunctive (13+)	1.25–20 mg	Somnolence Weight gain	Glucose/HbA1c Lipids Weight/BMI EPS/TD
Paliperidone (Invega)	Schizophrenia (12+)	3–12 mg	EPS Tachycardia Somnolence Weight gain Prolactin elevation	Glucose/HbA1c Lipids Weight/BMI EKG EPS/TD Symptoms of prolactin elevation
Perphenazine (Trilafon)	Psychotic disorder (12+)	12–64 mg	EPS Drowsiness Prolactin elevation	EPS/TD Symptoms of prolactin elevation
Quetiapine (Seroquel, Seroquel XR)	Schizophrenia (13+) Bipolar mania, monotherapy and adjunctive (10+)	12.5–800 mg	Sedation Orthostasis Weight gain	Glucose HbA1c Lipids Weight/BMI EKG EPS/TD
Risperidone (Risperdal)	Schizophrenia (13+) Bipolar mania, monotherapy and adjunctive (10+) Irritability in autism (5+)	0.25–6 mg	EPS Tachycardia Somnolence Weight gain Prolactin elevation	Glucose/HbA1c Lipids Weight/BMI EPS/TD Symptoms of prolactin elevation
Ziprasidone (Geodon)	Not approved for peds use	20–160 mg	Somnolence Akathisia	Glucose/HbA1c Lipids Weight/BMI EKG EPS/TD

*For medications not approved for pediatric use, usual approved adult dosing provided; dosing should be modified for children

Managing Psychotropic Treatment with Foster Children

Joshua D. Feder, MD, is a child and family psychiatrist with an active clinical practice in Solana Beach, California.

Dr. Feder has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

Janey is 5. She hits and she bites. Her third foster mother, Sandy, is thinking it's too much to handle. I am her new psychopharmacologist. Janey arrives with a thick chart documenting in utero substance exposure, early neglect, many placements, and symptoms consistent with many *DSM-5* diagnoses, including reactive attachment disorder, generalized anxiety disorder, disruptive mood dysregulation disorder, attention deficit hyperactivity disorder, and post-traumatic stress disorder.

Her symptoms include poor sleep, impulsivity, over-activity, irritability, easy startle, and sudden bursts of aggression. Her social and academic function are severely hampered. She is being treated with a combination of methylphenidate extended release 18 mg and risperidone 2 mg each morning; mixed amphetamine salts 5 mg in the afternoon; and quetiapine 25 mg at night. Once Sandy coaxes Janey inside, my new patient huddles near the door, with no intention of interacting.

And I'm supposed to evaluate Janey's medication regimen over the next 45 minutes.

Sound familiar? This is a typical patient in the schedule of a child psychiatrist who does work with foster families. The psychopathology is often extensive, and there are many social and economic factors impeding treatment.

Add to this the fact that, in response to the rising use of psychotropic medications in Medicaid and foster care populations, some states, including California, have implemented specific guidelines with requirements such as:

- A minimum amount of time with the child
- Collateral information from caregivers, teachers, therapists, and others
- Medical screening and follow-up
- Clear documentation of diagnoses and target symptoms
- Documentation of rationale for all medication decisions
- Emphasis on nonpharmacologic treatment and intervention

The reality, of course, is that kids like Janey and doctors like me are often left with less time and fewer resources than are needed. So, while medication never makes up for an inadequate plan, sometimes we are stuck with an inadequate plan.

The only way to successfully do these evaluations in a timely fashion is to break the process down into a series of manageable steps.

1. Establish rapport.

My first job is to spend at least five minutes listening to the struggles being experienced by the caregiver. Sandy says she has two other foster children and gained custody of Janey 3 months ago. She's clearly overwhelmed.

When you encounter a foster parent under this kind of pressure, it's important to take stock of the array of community supports that are available and to ensure that the parent is taking advantage of them. Our clinic has a checklist of such supports, and we give them to parents on intake. They include psychotherapy (both for the child and the parent), foster parent training, and others (see the accompanying article by Dr. Stewart on psychosocial interventions for more options).

2. Record the patient's symptoms, with an emphasis on (1) those that are most problematic for behavioral management, and (2) those that have been present over the past several weeks.

Foster kids often present with a long trail of documented psychiatric problems over the years. While it would be nice to review and digest all this information, you'd only have time for one patient per day if you did so. Instead, focus your attention and questions on the past few weeks.

In addition, acknowledge that not all symptoms are created equal. In a situation where the behavior is so problematic that the placement is in jeopardy, you need to focus on what you can to solve the acute problem. In this case, it is the hitting and biting that are creating the crisis.

3. Break down the behaviors in terms of discrete target symptoms that might be most amenable to medications.

At this point, you're not yet deciding on which meds to prescribe; you are simply thinking broadly about the possibilities. For Janey, I ascertain that she is often reacting to a very busy environment, and that the people working with her have been more focused on reducing the problematic behaviors rather than understanding them. Furthermore, she does have some moments of calm, connected play, and learning—a strength that I want to encourage.

4. Evaluate the list of medication options by balancing the potential benefits with the potential toxicity.

In general, we are most concerned about the side effects of antipsychotics. The major issues vary depending on the medication, and can include weight gain, dystonia, sedation, cognitive slowing, and akathisia, as well as a lowered seizure threshold. As I look at Janey's regimen, I'm concerned that she is on two different antipsychotics. While I will learn more about the rationale for the combination when I review old medical records, I suspect that the quetiapine was added for insomnia, which in turn was likely aggravated by the afternoon dose of mixed amphetamine salts. While risperidone may be

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Managing Psychotropic Treatment with Foster Children
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reducing Janey's irritability, I wonder if it is causing akathisia, which in turn could induce apparent over-activity and anxiety (Burcu M et al, *Journal of Child and Adolescent Psychopharmacology* 2014;24(3):112–119).

5. Document your informed consent process.

While some clinicians view informed consent as a pro forma exercise at the very end of an evaluation, when dealing with the foster care system, you are dealing with a highly scrutinized clinical environment. I think about informed consent as a process that happens throughout the evaluation as well as an ongoing conversation throughout treatment. For example, as I ask Sandy about Janey's symptoms, I educate her about risks and benefits of the common meds, and make sure she knows that there are non-medication options available. (A good list of questions to evaluate the need for medications can be found in this blog post in *Psychiatric Times*: www.bit.ly/1QZTMsw.)

6. After your evaluation, spend a few minutes creating a plan to obtain more information.

After your patient leaves, and before you see the next patient (who is probably already in the waiting room), create your plan for gaining more information. I schedule more time with Janey to try to establish some connection with her. I ask my front office staff to obtain other medical records and school records, and I send off an email to the therapist to find time for a quick chat at some point over the next couple of weeks. It turns out that there is a teacher at school who has a very positive and effective relationship with Janey, and we are able get a message to her to ask her to share with us more about that.

In addition, since we do not have time to complete our usual medical workup, I make a note to have my staff schedule the patient to come in a half hour earlier for her next appointment to get fasting labs and an EKG.

In this introductory meeting, the best I can do is to begin the assessment and treatment process. I review the diagnoses, the target symptoms, the current medication plan, including the risks of the medications, and whether neuroleptics are being used for FDA-approved indications. I try to talk about other options, including no medication, while listening to Sandy's fear that without more medication she will have to have Janey removed.

We are often faced with what appear to be insolvable problems, but in fact this is rarely the case. The key is our willingness to persevere, to re-review everything, look again for things we can change, and to persist in our efforts to develop rapport with children like Janey. We also have to devote the time needed to make calls to teachers and therapists, and to develop relationships with caregivers. Once Sandy is feeling heard, will she be more able to commit her energies to Janey and then rework the sleep hygiene plan and perhaps move away from quetiapine? When Janey figures out that I am unflappable and happy to see her, will she begin to settle down in my office and allow me to interact with her, play, talk a bit, and even get her height and weight? With regular calls to the teacher, will the school rethink its behavior plan, the one that is focused on compliance, and consider a revision that emphasizes empathic support?

We hear back from the teacher. We are able to have her summarize in three simple bullet points what works for her to share this with the entire team. These include: 1. Empathy first: She always responds to Janey's difficult moments as if Janey is in distress, not being mean; 2. Give her more time to respond: Patience and calmly waiting makes a big difference, allowing Janey to think and respond to requests; 3. "We" attitude—instead of speaking to Janey in terms of "You need to…," the teacher would frames her suggestions as a shared process with Janey. These three chief tips reduce the frequency and severity of Janey's difficulties substantially, obviating the need for some of her medications.

Six months later, Janey is happy to see me at our triweekly visit (the best I could arrange). We have gotten labs and an EKG, and replaced the quetiapine with a very small dose of diphenhydramine. Her body mass index has stabilized—a partial victory in the effort to reduce neuroleptic exposure. Janey still hits and bites, but a little less as Sandy is more able to hold steady at home; we have found more community supports for Sandy too. At school, Janey has become close with the media center aide, where she spends too much time, but at least she is not in as much open conflict with her peers. In light of these improvements, Sandy has agreed to try to decrease the risperidone to 1.5 mg on school days. Janey's therapist has been using an evidence-based trauma-informed approach all along. Her confidence in her work was thin when we began, but now she knows that I believe her approach is a good one and she is able to persist, with gradual progress for Janey in her ability to talk and play and draw about her life. We are moving in the right direction.

There is nothing easy about treating children in foster care. The problems are complicated and tough to treat, and there are no guarantees. The kids like Janey who I see sometimes respond, and sometimes they do not. Placements can change suddenly. In fact, by the time we are consulted, sometimes it is already too late: We might be doing an assessment with a caregiver that has given up. And sometimes we get things stabilized, then reunification processes begin, with the hope that a biological parent or family member will now take over. The challenges never end. My experience over many decades is that, with steady persistence, we usually make progress, enough to maintain hope.

Beyond Medications: Psychosocial Methods for Helping Challenging Kids

George H. Stewart, MD, is a child and adolescent psychiatrist working in Berkeley, California.

Dr. Stewart has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

Foster children tend to be over-medicated. Surveys show that foster youth receive 5 times the number of psychotropic medications, frequently three or four simultaneously, as privately insured children.

What else, beside medications, can we offer foster children who are often struggling with psychiatric issues and difficult and unfamiliar family environments? Medications can be very helpful, but they are designed to suppress symptoms, not to cure. Informed, empathic relationships heal, whether in psychotherapy, with foster parents, or with other caring people in a child's life.

In my own work with foster children, I use the following approach.

First, I do a comprehensive evaluation of these children. Beyond the usual information about behaviors and symptoms, I find it helpful to elicit a complete developmental, educational, medical, and family history. I am especially interested in a history of physical and sexual trauma (age of onset, duration, frequency, and nature of the trauma), separation from or loss of significant attachment figures, economic instability, and indicators of family dysfunction. Did they witness domestic violence, substance abuse, or sexual activity? Have they seen violence in their neighborhood? What circumstances brought the child into foster care? Is there a history of depression? Of suicidal thoughts or attempts? Have there been hospitalizations? Are there school difficulties? What is the nature of their peer relationships? And of course I obtain a complete medication history (and for older youth, a drug history). Who have been the most important adults in their lives? Are they currently in touch with family members? How often?

It is most common that they do not volunteer this information; so, if we want to know, we must ask them specifically. It is remarkable how often children can talk frankly about difficult issues if they are asked directly.

Example: An 11-year-old girl came through the emergency room after a sub-lethal suicide attempt. After she was triaged and stabilized, I interviewed her before discharge. When I asked about sexual abuse she hesitated for a second before saying, "No." I inquired about the hesitation, and she began to weep, revealing that an uncle had molested her for several months when she was 9 years old and she had never told anyone about it. Her foster parent, who accompanied her, was instantly empathic and the foster family rallied around her.

Once I have a good sense of the child's situation, I select from a variety of psychosocial interventions that are particularly helpful for foster children. There are two main categories: psychotherapies and community-based programs.

1. Psychotherapies

Trauma-informed individual psychotherapy. Trauma-informed therapy (Weiner DA et al, *Children and Youth Services Review* 2009;31(11):1199–1205) entails the strategies such as recognizing the impact of trauma on your patient's development and coping abilities, helping your patient develop a sense of empowerment by emphasizing that they are not at fault, and minimizing the possibility of re-traumatization, especially rejecting invitations to do the same subtly in the therapy.

The core element of these therapies is working individually with a traumatized child to encourage them to express in words, play, or art what they have been expressing in actions.

Example: Mandy, a sexually-abused 16-year-old, wears increasingly provocative clothing and sits so as to accentuate and display her figure. Part of the task of therapy is to help her to identify what she seeks—love, caring, self-respect, and protection-—and how to obtain the same while avoiding shaming, scolding, or exhibiting arousal.

Trauma Systems Therapy (TST). See *CCPR,* June 2015 for an in-depth look at TST. As opposed to individual psychotherapy, TST involves a team that evaluates the child's environment for triggers that may be not be recognized in individual therapy.

Targeted group therapy. There are many varieties of group therapy designed for specific populations. For example, Dialectical Behavior Therapy (DBT) is effective for those with borderline traits (cutting, substance abuse, repeated suicide attempts). Same-sex groups for sexually molested girls/boys are helpful because they help youth see that they are not alone in their difficult experiences, just as LGBT groups can assist with the stresses of alternative sexual orientation/gender identification.

Experiential and expressive therapies and programs. There are plenty of non-traditional therapies available. These include yoga, meditation, exercise, equine therapy, wilderness programs designed for foster youth, pet therapy, and art and music therapies. Any of these may provide a foster child with additional self-esteem and insight, augment their investment in themselves, and allow them positive experiences. Finding an area in which a child has an interest and helping them to develop their skills in it can be very useful. Frequently the county departments of mental health or social services will have a current directory of what is available.

2. Community-based services

Foster parent training. Many counties have contracted with non-profit organizations to provide training for foster parents. Foster children have

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Beyond Medications: Psychosocial Methods for Helping Challenging Kids

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been traumatized by their removal from their families, as well as by the conditions that led to their removal. Their behaviors can be remarkably trying, and foster parents can gain skills and understanding through training that increase the likelihood of success for the child in that household. The last thing a foster child needs is placement failure with another rejection.

Example: 5-year-old David was previously identified as autistic. Surprisingly, and contrary to behaviors I would have expected in an autistic patient, I noticed that he dramatically demanded attention and attachment from his detached foster mother. Helping the mother to identify his need and to meet it led to a significant improvement in his disruptive behaviors.

Family Finding. Family Finding is an approach that relies on locating supportive relatives of a foster child, who can then become engaged with the child's life. The technique was developed by Kevin Campbell, who founded the National Institute for Permanent Family Connectedness. Here's how it works: Trained master's-level clinicians enter any and all information they can obtain about a child's family into a specially designed Internet search database. They retrieve names and contact information and make initial inquiries to ascertain that the relatives are, in fact, blood relatives of the child. The relatives are contacted to assess their degree of interest in making contact with the child. The child is not informed of this until late in the process to avoid what could be catastrophic disappointment. If it goes well, supervised contact is arranged between the child and their interested family member. Remarkable numbers of family members, close and distant, are generally found.

An auntie in New York who reliably sends an email or a card to her nephew in California can make a crucial difference for a child isolated from family members, providing the promise of more intimate and enduring family connection. Sometimes Family Finding can lead to adoption; more often it can provide an ongoing source of support, love, and lasting family connection for the child. Most children need meaningful relationships with family in order to have hope for their future.

Example: Bob was a severely sexually abused, neglected, and cognitively-impaired 15-year-old in a secure residential treatment center. After a year of no progress, we employed Family Finding, locating relatives in Texas, Oregon, and New York. Some visited him, he traveled to Oregon to visit another, and others sent him regular cards and emails. Bob became hopeful, much less assaultive, and an eager participant in his treatment program.

Wraparound services. Wraparound teams are special clinical support networks funded in systems of care under contract with county departments of social services and of mental health. The teams usually consist of a child care worker, a master's-level clinician, a child psychiatrist, and a supervising social worker. You can enlist wraparound teams by calling the child's court-appointed social worker. What, specifically, do these teams do? Here are a few examples: Make regular home visits supportive of both foster parents and the foster child; have after-school Big Brother/Big Sister-type relationships and activities; visit the school to problem-solve bullying, depression, learning disabilities, academic delays, and other issues related to school failure; and provide individual and family psychotherapy.

Therapeutic Behavioral Services (TBS). TBS is a time-limited, targeted behavior modification intervention. When available, it is generally provided by nonprofit organizations contracting with each county department of mental health. A clinician meets with the family (or school) and child, then identifies one or two problematic behaviors, such as tantrums at bedtime or difficulty with transitions in school. Working directly with the child, antecedents are elicited, modifications in routine or the environment are considered, and replacement behaviors are introduced and tested.

Court-appointed Special Advocates (CASA). CASAs are specially trained volunteers who are assigned to foster children. Their job is to advocate for them in court, in school, and elsewhere. They are available in most counties and are a free service. The unique features of CASA are: 1) They often will have a continuous, caring relationship with the child for years; 2) Their task is purely to advocate for the child, with no governmental, legal, or other conflicting agenda. To find a CASA in your area, simply look on their website (either local or national).

The Individual Education Plan (IEP) meeting. The majority of foster children have IEPs, which are mandated by most public school systems for children who have psychological issues impeding their ability to learn. The IEP meeting occurs when initiated by the child's guardian or by the school, is reviewed annually, and usually includes the following participants: current teacher(s), school psychologist, special education staff, child, guardian/parent, CASA, and any other relevant providers, including members of a child's wraparound team. Why should we take the time to actually attend these meetings? A child's school success can be a key to improved self-esteem and, eventually, to a constructive life. School failure is a strong predictor of incarceration at a later age. We can discuss the child's trauma history, perceptions of unsafety, attachment issues, low self-esteem, a need to re-create their trauma, etc., bringing empathy and a deeper understanding of the child to the meeting. My experience is that our presence is strongly sought and our voice well-heard.

Crisis Services. When children are in crisis, we are tempted to rely heavily on medications. But don't neglect to consider the variety of crisis services in your

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Foster Care and Child Psychiatry: A Primer

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One of the challenges of working with children in foster care is that there is often no one who knows the child well or can report on the longitudinal course of symptoms. Many children have jumped from provider to provider and may be taking multiple psychiatric medications. If you are a new provider caring for such a child, get your own history of symptoms before continuing to treat apparent mania or psychosis that may actually be complex PTSD, depression, or simply a child's acting out in a maladaptive attempt to gain control. Some children believe that if they act badly enough in the foster home they will be returned to their parents. Alternatively, they may anticipate rejection by the foster family and act out to elicit the expected rejection—to avoid getting attached to the new caregivers and then being disappointed.

The bottom line is that foster care children are likely to have significant psychiatric issues, and the best treatment includes a coordinated team of foster parents, mental health professionals, and child welfare services staff such as social workers and court-appointed special advocates. We'll get into the details of treatment recommendations in the other articles in this issue.

Expert Interview

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so slurred that she was scheduled for a frenulectomy because they thought she was tongue-tied. She began taking martial arts classes, and her instructor said she spent the first sessions just teaching her posture and to get her chin off her chest; she literally had to learn to look up and stand straight. And this gave her the power she needed. She became part of a tapering trial, and when they tapered her off the multiple medications she had been on, they found her reading the dictionary in her room when she was previously functioning at a kindergarten level. She was able to engage in therapy and, needless to say, her surgery was cancelled.

CCPR: Are there any other similar examples?

Karen de Sá: Yes, we wrote about a young man who had been abandoned by his birth mother, adopted by a foster mother together with his brother, and then she kept the brother and gave him up. So he had essentially lost two moms. He was in a group home at age 10 and was in 30 placements the rest of his young life, never lasting anywhere for more than a few weeks or months. He was on 4 medications at one time, including an adult dose of Risperdal, and was very aggressive. He finally found a court-appointed special advocate who had grown up in foster care herself, someone who wasn't just being paid to be there. In getting to know him, she discovered he really needed connection with his family. So she started taking him to see his brother on a regular basis. They found his mom, who he hadn't seen in 15 years, and they arranged a reunion. So for this child, grounding was just about reconnecting with his family, and no one had really listened to that; he was just another foster kid. This volunteer advocate fought hard to give him a voice so he was able to get support from his attorney and social worker to reduce his medication.

CCPR: What sort of guidelines has California put in place for medicating foster kids?

Karen de Sá: The California Department of Health Care Service just put out the following guidelines that include:

- Offer nondrug therapies and give preference to medications approved by the FDA for use in children.
- Keep dosages to a minimum with a "start low and go slow" approach.
- Discourage the use of two or more meds.
- Periodically wean children off psychotropics altogether to see if they are working.

CCPR: Most psychiatrists would agree that those guidelines make sense. Probably the only one that might be problematic is to stick to FDA-approved drugs because there are so few out there. Can you give me a flavor for the legislative pushes in California that were just passed?

Karen de Sá: Sure. One new law provides basic training for judges, lawyers, social workers, caregivers, and foster parents on how psychotropics work and what red flags and side effects to look for. Another strengthens the role of foster care public health nurses, allowing them access to medical records and charging them with the oversight of psychiatric drug prescribing. Another law increases the oversight of group homes; those having a high prescribing rate have to formulate a corrective action plan that includes more appropriate intervention therapies.

CCPR: Let's address the elephant in the room—the pharmaceutical industry. What role have they played in this situation?

Karen de Sá: For our investigation, we took the lists of all the names of all the prescribers of psychotropic medications in California to foster youth, and we compared them to a list of all the doctors in the state. Of those who had received money from the drug companies, the two main findings are concerning. One is that foster care prescribers, in particular, have taken more money from drug companies than your average California doctor. Second, when we broke out the lower prescribers and the higher prescribers, those who tended to prescribe more also accepted more in gifts, payments, travel, and meal money. So that's a clear correlation between high prescribing and financial rewards from pharmaceutical companies. And that's a scary thing if you're a foster kid (for the full report, see http://webspecial.mercurynews.com/druggedkids/?page=pt3).

CCPR: Absolutely. Thank you, Karen.

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Below are the questions for this month's CME post-test. This page is intended as a study guide. Please complete the test online at www.TheCarlatChildReport.com. Note: Learning objectives are listed on p. 1.

1. In what type of foster care environment would you find the highest prescribing rates for psychiatric medications? (Learning Objective #2)
   - [ ] a. Group homes
   - [ ] b. Pre-adoptive families
   - [ ] c. Kinship care
   - [ ] d. Long-term foster families

2. What is the name of the community-based service/program whose hallmark is creating a continuous, caring relationship between a non-paid adult and a foster child over a period of years? (LO #3)
   - [ ] a. Wraparound Service
   - [ ] b. Therapeutic Behavioral Service (TBS)
   - [ ] c. Court-appointed Special Advocates (CASA)
   - [ ] d. Family Finding

3. What percentage of foster care children have significant psychiatric problems at some point during their time in foster care? (LO #1)
   - [ ] a. 75% [ ] b. 33% [ ] c. 25% [ ] d. 66%

4. Which of the following antipsychotic medications is FDA indicated for pediatric use? (LO #2)
   - [ ] a. Clozapine (Clozaril) [ ] b. Lurasidone (Latuda)
   - [ ] c. Ziprasidone (Geodon) [ ] d. Aripiprazole (Abilify)

5. Which of the following is *not* a type of legal hearing involved in foster care cases? (LO #1)
   - [ ] a. Dispositional hearing [ ] b. Detention hearing
   - [ ] c. Jurisdictional hearing [ ] d. Fitness hearing

6. The type of non-traditional psychotherapy that involves yoga, meditation, exercise, or art or music therapy is called: (LO #3)
   - [ ] a. Therapeutic Behavioral Services
   - [ ] b. Trauma Systems Therapy
   - [ ] c. Experiential and Expressive Therapy
   - [ ] d. Dialectical Behavior Therapy

7. Which of the following is an appropriate guideline to follow for medication use in foster children? (LO #2)
   - [ ] a. When possible, choose agents with FDA indications for pediatric use
   - [ ] b. Consider monotherapy or polypharmacy to start
   - [ ] c. Initiate medication treatment if it is a condition for placement
   - [ ] d. Prioritize past symptoms versus most recent ones to target with medication use

8. According to one study of foster care adolescents, what is the strongest predictor of having a lifetime psychiatric disorder? (LO #1)
   - [ ] a. The number of different homes the child had been placed in
   - [ ] b. The number of different types of maltreatment the child had experienced
   - [ ] c. The age in which the child entered the foster care system
   - [ ] d. The number of court hearings the child had been through

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This Issue's Focus:
Foster Care and Psychiatry

Next Time in *The Carlat Child Psychiatry Report:* Antidepressant Use in Children

Beyond Medications: Psychosocial Methods for Helping Challenging Kids

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area. For example, mobile crisis teams can be summoned to the home where they can assist in the de-escalation of a crisis and/or triage children for a higher level of care if needed. Crisis stabilization units (CSU) are fairly new, freestanding county facilities where a child can be safely contained for up to 24 hours. While there, they are assessed for hospitalization or for discharge with continued outpatient services.

As you can see, the options for psychosocial treatment are plentiful. Unfortunately, as detailed in a recent newspaper series on the California foster care system (see this month's Q&A for an interview with the lead journalist on that series), these interventions aren't being used as much as they should. Why? There are various reasons. These include a lack of funding, an absence of a unified directory of existing services, a lack of familiarity or fluency by the child psychiatrist with the broad range of possible interventions, a perceived lack of time to initiate them, and even a conviction by the child psychiatrist that their role is limited to prescribing medication. Hopefully, you will be able to add some of these tools to your kit and deploy them for your troubled foster patients.