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Background and Context

The use of psychotropic medication among children and youth in the United States has increased significantly over the last two decades, particularly for children and youth in foster care (Longhofer, Floersch, & Okpych, 2011; Raghavan, Lama, Kohl, & Hamilton, 2010). Raghavan and colleagues (2005) estimate that 13% of all children and youth in the child welfare system nationwide receive psychotropic medications compared to 4% of children and youth in the general population. In 2014 the San Jose Mercury News found that from 2004 to 2014, nearly 1 out of 4 adolescents in the California foster care system received psychotropic medications—3.5 times the rate for all adolescents nationwide. Of children and youth in care who were prescribed psychotropic medications, 60% received the strongest class—antipsychotics. What is particularly concerning is the prescription of multiple medications (i.e., polypharmacy). The newspaper study also found that in 2013, 12.2% of children and youth in care who were prescribed medications were prescribed more than one medication at a time.

Mackie and colleagues (2011) list a number of factors, which may or may not be related to clinical need, that explain why the population of children and youth are disproportionately prescribed psychotropic medications, including: higher rates of trauma victimization and mental health disorders found in this population; trauma caused by being removed from family of origin and multiple placement changes thereafter; and the complex emotional and behavioral symptoms that accompany all these underlying circumstances; lack of clear oversight and monitoring guidelines and protocols; an increase in medication prescriptions in outpatient settings; and inadequate access to Medicaid services.

Research repeatedly finds that children and youth in the foster care system are diagnosed with mental health disorders more often than children not in foster care and are therefore more likely to be prescribed psychotropic medications (Longhofer, Floersch, & Okpych, 2011; Sheldon, Berwick, & Hyde, 2011). The most common diagnoses among children and youth in foster care are conduct disorder/oppositional defiant disorder, depression, attention deficit/hyperactivity disorder, and posttraumatic stress disorder. Commonly prescribed medications for children and youth in foster care include antipsychotics to treat schizophrenia, bipolar disorder, and autism with irritability; stimulants to
treat symptoms of attention deficit hyperactivity disorder; antidepressants to treat major depression and obsessive compulsive disorder; and mood stabilizers for aggressive behavior and unspecified emotional problems.

In response to this data, California has taken steps to build upon previous legislation and expand and develop new guidelines that continue to promote the basic principles of safety, permanency, and wellbeing, with the added goal of reducing short- and long-term harm caused by inappropriate prescriptions and use of psychotropic medications. As part of the Foster Care Quality Improvement Project, The California Department of Health Care Services (DHCS) and the CDSS released the California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care, 2015. The new guidelines create a shared understanding of oversight and monitoring of psychotropic medication practices for both child welfare services and mental health services. The guidelines set expectations for physicians, social workers, mature children and youth, parents, caregivers, Tribal members, and all other psychotropic medication stakeholders to collaborate in strengthening the oversight and monitoring of psychotropic medications ("California guidelines," 2015). All-County Information Notice No. 1-05-14 provides details about sharing required information with caregivers to facilitate their involvement in providing care for children and youth.

Senate Bill 238, signed into law by Governor Brown on October 6th of 2015 stipulates that certain professionals and others who work with children and youth in foster care should be provided training about important topics related to the administration of psychotropic medication to those children and youth. Specifically, training about psychotropic medication and trauma as related to children and youth in foster care is to be provided to group home administrators, foster parents, child welfare social workers, probation officers, public health nurses, dependency court judges and attorneys, court appointed counsel and special advocates along with information about behavioral health and substance use.

Several media sources and other studies have recently revealed that the rate of psychotropic medication prescriptions for children and youth in foster care is higher than the general population. An alarming number of children have been prescribed multiple potent classes of drugs to be taken simultaneously. This coverage and other movements to improve mental health services in foster care produced several reform laws. These laws make explicit that children and youth in foster care, along with their families and representatives, must be allowed to provide input into whether or not psychotropic medication is part of their treatment plan.

Rather than working from the assumption that symptoms and behaviors are necessarily indicative of mental illness, these reforms encourage the use of a trauma-informed lens to view the child’s environment and experiences as possible sources of behavior or symptoms and to explore a broad range of treatment options.
Psychotropic medications are one tool among many that may be used to address behavioral health concerns. They must be considered very carefully as the long-term effects of these medications on developing brains is unknown and potential side effects can be severe.

At the time of this writing, the California Department of Social Services is engaged in the development of the California Child Welfare Core Practice Model, which subsumes the Pathways to Mental Health Services Core Practice Model within a larger practice framework that integrates the child welfare system with other child- and family-serving systems in the public sector and their partners. In turn, the California Child Welfare Core Practice Model is part of a tripartite “Shared Approach to California’s Children, Youth, and Families” with the public systems of behavioral health and juvenile justice, which are also in process of developing practice models for their respective fields of practice. An “Integrated Statewide Training Plan” is currently underway which will reflect the practice and service delivery environments of the child welfare, behavioral health, and juvenile justice systems under the “Shared Approach.” This curriculum is congruent with the developing California Child Welfare Core Practice Model and with the forthcoming “Integrated Statewide Training Plan.”

The Core Practice Model (CPM) sets the foundation for a common practice framework that integrates behavioral health screenings, referrals, service planning, service delivery, and overall coordination and case management among all those involved in working with children who receive services from child welfare and behavioral health systems in the public sector. The effective engagement of families in the referral and treatment process for their children is integral to this mission. The CPM describes standards and expectations for practice behaviors by child welfare and behavioral health staff that ensures and supports meaningful participation by families in the care and treatment of their children.

Child and family teaming is a service requirement for children who qualify for Intensive Care Coordination, and will soon be the standard throughout child welfare. For children and youth with identified mental health issues, child and family teaming is strongly recommended. Children and youth for whom psychotropic medication is being requested from the court will likely fall into one of these categories.
Curriculum Introduction

Duration: One Day (9:00am-4:00pm, one-hour lunch break, two 15-minute breaks)

This curriculum provides:

- An overview of the uses, benefits, and risks of psychotropic medication.
- Information about trauma and how it can inform care and treatment decisions.
- Guidance for professionals to create treatment plans and team with families and other professionals to make and monitor treatment decisions (e.g., public health nurses, behavioral health providers, school personnel, doctors, juvenile probation officers, CASAs, and other individuals in the family support network such as coaches, clergy, etc.).
- How to locate and use the forms and informational materials in the court approval process (JV-220).

The core resource for this topic is the California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care. The most updated version will be available at:


The Guidelines outline

- Basic principles and values,
- Expectations regarding the development and monitoring of treatment plans (emotional and behavioral health care, psychosocial services and non-pharmacological treatments),
- Principles for informed consent to medication, and
- Principles governing medication safety.

California’s Pathways to Mental Health practice model is also a helpful resource. The most recent version of which may be found here:


As is the California child welfare core practice model (CPM), the most recent version of which can be found here:

http://calswec.berkeley.edu/california-child-welfare-core-practice-model-0

The essential document, the Foster Care Youth’s Mental Health Bill of Rights, can be found here:


The California Rules of Court 5.640, which govern the JV-220 court process can be found at:

http://www.courts.ca.gov/cms/rules/index.cfm?title=five&linkid=rule5_640

Accepted practice and local rules of court vary across counties, and these materials will not cover all these variances. Knowing the specific practices of the county for which you are working is an important responsibility, especially when working with children and youth who have mental or behavioral health needs.


For questions regarding the curriculum, contact Shay K. O’Brien, skobrien@berkeley.edu or Melissa Connelly, mconnelly@berkeley.edu, or call CalSWEC at 510-642-9272.
Agenda

Segment 1  Welcome and Introductions
Segment 2  Laws and Regulations
Segment 3  Court Process and Forms

BREAK

Segment 4  Trauma
Segment 5  Accessing Services

LUNCH

Segment 6  Psychotropic Medication

BREAK

Segment 7  Using the California Guidelines
Segment 8  Wrap-Up and Evaluations
Learning Objectives

**Knowledge**

**K1:** Trainees will be able to name at least three key points in the laws and regulations that govern administration of psychotropic medications to children and youth in foster care in California.

**K2:** Trainees will be able to name at least one of the basic principles of trauma-informed care as they relate to use of psychotropic medication in foster care.

**K3:** Trainees will be able to name at least two common behavioral health diagnoses and the related treatment options (both psychosocial and medical) for children, youth, and young adults in foster care.

**K4:** Trainees will be able to describe what to do if side effects are noticed or reported by a child, youth, or young adult in foster care who is taking prescribed psychotropic medication.

**K5:** Trainees will be able to locate and utilize the correct state required forms (JV-217 through JV-224) when a medical provider is starting or continuing a psychotropic medication for a child or youth in foster care.

**K6:** Trainees will be able to describe the notification processes used in requesting and monitoring administration of psychotropic medications.

**Skills**

**S1:** Using sample plans, trainees will utilize the *California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care* and the tools in its appendices to evaluate and modify treatment plans that include psychotropic medication decisions.
   a. Prescribing Standards by Age Group,
   b. Parameters for Use of Psychotropic Medication for Children and Adolescents,
   c. Challenges in Diagnosis and Prescribing Psychotropic Medication, and
   d. Algorithm/Decision Tree for Prescribing Psychotropic Medication.

**S2:** Using a vignette, trainees will be able to identify:
   a. The relevant parties and documentation to be included in the court process,
   b. Those parties’ rights and obligations, and
   c. The timeline for court requests, decisions, and notifications.

**Values**

**V1:** Trainees will value building on child and family resilience and strengths in both formal and informal services used to ameliorate the negative effects of
   a. abuse and/or neglect;
   b. emotional, cognitive, and/or behavioral dysregulations; and
   c. potential mental illness.

**V2:** Trainees will value ensuring that the voices of children, youth, and young adults are incorporated into treatment plans and medication decisions.

**V3:** Trainees will value working with a multi-disciplinary team to understand and manage the use of psychotropic medication by children, youth, and young adults in foster care.
Segment 1: Welcome and Introductions

Please introduce yourself by providing

- Your name
- Your county/department/agency/unit
- The role you play in Foster Care

Activity: Group Agreements

Some examples of these agreements are:

- Respect each other’s perspectives and experience.
- Mindfully participate by keeping the environment collegial and productive.
- If an issue arises, address the instructor on the side, one-on-one, rather than in front of the whole group.
- Avoid interrupting, ridiculing, or talking over each other.
- Consider privacy and confidentiality concerns carefully before you discuss any case or use a current or former case as an example.

You may use this space to make note of the agreements your group makes.
Segment 2: Laws and Regulations

Definition of Psychotropic Medication

In the Welfare and Institutions Code, psychotropic medications are defined as:

“Those medications prescribed to affect the central nervous system to treat psychiatric disorders or illnesses. They may include, but are not limited to, anxiolytic agents, antidepressants, mood stabilizers, antipsychotic medications, anti-Parkinson agents, hypnotics, medications for dementia, and psychostimulants.”

The California Department of Social Services and the Department of Health Care Services have chosen this definition in their Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care document, which we will use later in the day.

Big Picture

Concerns that have been raised by research studies, government reports and media coverage include: overmedication, off-label medication, multiple prescriptions, insufficient monitoring, and medicating very young patients.

Research and media sources reveal that the rate of psychotropic medication prescriptions in foster care is higher than the general population, children have been prescribed multiple potent classes of drugs to be taken simultaneously and without a schedule to evaluate effectiveness (in other words, permanently). This coverage and other movements to improve mental health services in foster care produced several reform laws.

Input: These laws make explicit that children and youth in foster care, along with their families and representatives, must be allowed to provide input into whether or not psychotropic medication is part of their treatment plan.

Trauma: Rather than working from the assumption that symptoms and behaviors are necessarily indicative of mental illness, these reforms encourage the use of a trauma-informed lens to view the child’s environment and experiences as possible sources of behavior or symptoms and to explore a broad range of treatment options.

Broad array of services: Psychotropic medications are only one tool among many that may be used to address behavioral health concerns. They must be considered very carefully as the long-term effects of these medications on developing brains is unknown and potential side effects can be severe.

Goal is to get appropriate, quality, accessible mental/behavioral health services to children and youth in care.

Senate Bill 238

Court authorization process

- Only a juvenile court judicial officer can order the administration of psychotropic medications to a child or youth in foster care (except rare cases we’ll cover later)
- That officer may only do so based upon a request from a physician.
- That physician will provide reasons for the request and a description of the child’s diagnosis and symptoms.
- The court will receive information about the child’s overall mental health assessment and treatment plan, and process for periodic oversight and evaluation to be facilitated by the social worker, public health nurse or other county staff.
- Caregiver receives notice within two days of court’s decision
Child and Family Input

- Provides opportunity for the child and his or her family and caregiver, court-appointed special advocate, the child’s tribe, or others to provide input on the medications being requested.
- Requires that the child’s caregiver receive a copy of any resulting court order.

Public Health Nurses

- SB 238 clarifies the public health nursing program in child welfare with the purpose of promoting and enhancing the physical, mental, dental, and developmental well-being of children in the child welfare system.
- PHNs will collect and document medical records, assist with referrals, and participate in medical care planning and coordination.

Monthly State Data

- Requires the California Department of Social Services is required to issue a monthly report to indicate when red flags are present. For example,
  - when multiple medications are prescribed for the same child, or
  - when unusually high doses are indicated, or
  - when prescriptions are for children who are 5 years old or younger.
- Counties are subsequently required to share relevant information with appropriate juvenile court, attorneys, county department of behavioral health, and CASAs.

Recommends this training

- SB 238 suggests training about the authorization, uses, risks, and benefits of psychotropic medication as well as training on self-administration, oversight, and monitoring of those medications.
- The law suggests that the training include information about trauma, substance use disorder, and mental health treatments.

Senate Bill 319

Senate Bill 319 addresses the role of Foster Care Public Health Nurses.

Public health nurses will:

- monitor use of psychotropic medication by children and youth in foster care,
- document initial and follow-up health screenings,
- collect health information to determine appropriate referral,
- help children and families connect with the services they need,
- assist with treatment planning,
- assess progress toward treatment goals, and
- advocate to ensure that the health needs of the child are met and that the child and family can make informed decisions about their own medical treatment and health care goals.

The specific practices and protocols for these activities will vary according to county decisions.

Senate Bill 484

This law applies primarily to Group Homes. Runaway and emergency shelters are exempted from the requirements of this bill.
Group homes are required to use psychotropic medication in accordance with the written directions of the prescribing physician as authorized by the juvenile court.

Group Homes are to maintain specific information in the child’s records
- A copy of the court order that authorizes the administration of prescribed medication
- A separate log for each medication the child is taking that includes:
  - the name of the medication,
  - the date of prescription,
  - the quantity of medicine and the number of refills,
  - dosage and directions, and
  - the date and time when the child took each dose.

This law also delineates how the state will identify group homes that warrant additional review and mandates visits at least once a year to identified facilities.

SB 484 authorizes the department of social services to share information about these visits with county placing agencies, social workers and probation officers, the court, and dependency council or the Medical Board of California.

Group homes who have had a visit or report will be allowed to submit improvement plans to CDSS within 30 days of that visit.

Group homes will be required to implement alternative programs and services that adhere to new performance standards and outcome measures to be designed by CDSS by January 1, 2017

**Legislative Updates**

Senate Bills
- 1174—prescriber-oversight bill allowing Medical Board of California to examine prescription patterns
- 1291—improves transparency and tracking of mental health services for children and youth in foster care

Information about new California laws concerning health can be found here: [http://www.dhcs.ca.gov/formsandpubs/laws/Pages/LawsandRegulations.aspx](http://www.dhcs.ca.gov/formsandpubs/laws/Pages/LawsandRegulations.aspx)

Links to the investigative journalism done by San Jose Mercury-News can be found here: [http://www.mercurynews.com/tag/drugging-our-kids/](http://www.mercurynews.com/tag/drugging-our-kids/)

**Supplemental Materials:**
- State Audit Summary
- ACF, Children’s Bureau Information Memorandum 12-03
- Full text of SB 238
- Full text of SB 319
- Full text of SB 484
- ACL 16-48 Role of Foster Care Public Health Nurses
Segment 3: Court Process and Forms

Court Process

Much of the work done by the CFT or other treatment team especially the health history, past treatments documentation and risk/benefit analysis, will be useful for the court if psychotropic medication is selected as part of the treatment plan.

The new court process used to consider a requested psychotropic medication be administered to a child or youth in care became effective on July 1st, 2016. It strengthens the continuity, quality, and coordination of care. Continuity is improved by the sharing of medical and treatment history across agencies, quality of care is enhanced by improved monitoring and clear expectations, and coordination is easier because social workers and public health nurses have easier access to necessary information.

Judicial Review

By law, a child who is a ward or dependent of juvenile court or in foster care may not receive psychotropic medication without a court order. The Judicial Council has created a series of forms used to request this order from the court. They make up the “JV-220 Process.”

There are only three exceptions to this mandate. One exception is if the child or youth lives in an out-of-home facility that is not considered foster care. Another exception is when there is a previous court order that gives the child’s parents the authority to approve or refuse the medication. The final exception is in the case of an emergency. A doctor may administer psychotropic medication to a child if they pose a serious risk to themselves or others, to prevent death or serious harm, or if waiting would create significant suffering. After emergency administration of medication, the doctor has no more than 2 days to seek court authorization through the JV-220 process.

Judicial approval is sought by the social worker or probation officer with the child’s prescribing physician. They work in collaboration with the child, his or her court and tribal representatives, along with family members and caregivers.

Public Health Nurses are key members of treatment teams for children and youth in foster care. Civil Code section 56.103 states that medical information, barring psychotherapy notes, and other restricted health information may be shared with Public Health Nurses or PHNs, but the Rules of Court that delineate the JV-220 process do not include PHNs explicitly. Counties will vary in the approach they take to incorporating the role of PHNs and the data sharing activities.

Exceptions

Judicial approval is required except in these circumstances.

- Continuation of medicine from before they were in foster care.
- Parent/legal guardian remains the only person allowed to consent to treatment.
- Emergency—rare and short-term
- Non-Minor Dependents have their own consent to grant or deny, Court has no authority
- Child or youth is living in out-of-home placement not considered foster care (e.g. juvenile detention or voluntary placement)
Required Forms

Here is a quick introduction to the forms used in the court approval process for requesting and administering a psychotropic medication to a child in foster care. Use of them is sometimes called the “JV-220 Process.”

- **JV-220** is the form that initiates the request to administer psychotropic drugs to a child or youth in care.
- **JV-220(A)** is an attachment to the JV-220 and contains the physician’s statement. It must accompany the JV-220, unless the request is to continue an ongoing treatment without changes and is requested by the same doctor. In that case, JV-220(B) should be attached. These JV-220 forms are commonly referred to as the Application.
- **JV-221** is the form that shows the Court that all parties with a right to receive notice were served a copy of the Application and attachments. We will cover these parties more thoroughly in a few moments.
- **JV-223** is the Order on the Application and is the form the Court uses to either grant or deny the Application for Psychotropic Medication.
- **JV-224** is filed with the Court by the social worker or probation officer at least 10 calendar days before each progress review.
- **JV-217 INFO** is a Guide that provides brief descriptions of all the forms related to the Application for Psychotropic Medication. It is sent along with notifications of a pending Application.

Optional Forms

In addition to the required forms, there are some that the family and treatment team may decide to use. It is important to note that while these forms are listed as “optional,” that does not mean that seeking the input of these individuals is optional. It is just that the use of these specific forms is not required. Involved parties may communicate their thoughts and feelings using other means, but their input should be sought. The JV-218 form can be used by the child for whom the medication is requested. It is one of a variety of methods the child may use to provide their input to the Court.

**JV-219** is a similar form that may be used by the caregiver, CASA, or Tribe to provide a statement about their feelings related to the Application for administration of a psychotropic medication to the child in question. **JV-222** form is filed when the parent or guardian, the attorney of record for a parent or guardian, the child, the child’s attorney or guardian ad litem, or the Indian child’s Tribe does not agree that the child should take the recommended medication.

**Supplemental Materials:**
- JV-220 Forms provided by Trainer
- JV-220 Handouts provided by Trainer
- California Rules of Court 5.640
- American Bar Association—Psychotropic Medication and Children in Foster Care: Tips for Advocates and Judges
Segment 4: Trauma

Definition of Trauma

Substance Abuse Mental Health Services Administration’s definition of trauma:

“Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual’s functioning and physical, social, emotional, or spiritual well-being.”

The inclusion of “set of circumstances” incorporates the experience of neglect, which is the most frequent reason that children and youth are removed from their homes. Therefore, this definition is important for work with the foster care population. It doesn’t completely align with the diagnostic criteria for PTSD, so this is an area that requires attention.

The trauma-informed approach is of particular importance when we are discussing mental and behavioral health interventions. Often, the signs and symptoms of trauma can resemble those of mental illness or behavior disorders. These symptoms and behaviors might then be treated as a mental illness or chemical imbalance and/or with psychotropic medications, thus causing missed opportunities to address the trauma as well as increasing the likelihood of adding undue stress or even re-traumatizing the individual.

The three E’s of trauma

This definition highlights the three components of trauma, which are the event or the circumstance, the experience of the event, and the effect of the experience.

THE EVENT: The source of potential trauma is an event or circumstance that causes significant stress. Not every child exposed to stress will develop trauma. Examples may include the actual or extreme threat of physical or psychological harm or severe, life-threatening neglect. These events and circumstances may happen as a single occurrence or repeatedly over time. Trauma can also occur when an individual witnesses extreme threats or stressful circumstances experienced by someone they care about.

EXPERIENCE: The singular experience an individual has of these events or circumstances determines whether it is a traumatic event. A particular event may be traumatic for one person, but not for another. Feelings of powerlessness, humiliation, guilt, shame, betrayal, or silencing often shape the experience of the event. How the event is experienced may be linked to a range of factors including the individual’s cultural beliefs, availability of social supports, or developmental stage at the time the event or events occurred.

EFFECTS: A critical component of determining if an experience was traumatic for an individual is the presence of long-lasting and adverse effects. They may occur immediately, or not. Sometimes adverse effects are not noticed until much later, but are nonetheless caused by the previous Events and Experiences.

Trauma and Foster Care

Children and youth currently or formerly in foster care have lived through at least one event which could be traumatic for them: they were removed from their home. They lost access to their family for at least some time. Services within the foster care system, which are designed to protect children from harm, can—in and of themselves—be traumatizing, despite our best efforts. For example, removal from their home, separation from siblings, pets, and familiar environment, chaotic placement, etc. There is also the significant loss, abuse, and/or neglect that the child experienced which resulted in removal from their home. Any of these events can cause trauma. Therefore, it makes sense to view this population through the lens of potential trauma and its effects.
Symptoms like sleep problems, toileting problems, anger, aggressive behaviors, depression, or difficulty sustaining attention are all identified by the American Academy of Pediatrics (2015) as possible presentations from children with a history of adverse and potentially traumatic experiences.

*These behaviors may be adaptive and protective when the child is in the stressful environment, but can be misunderstood as pathologic when they are removed from that environment. Not every dysregulation is indicative of a disease.*

That’s why it is important to carefully screen for and evaluate trauma when assessing the needs of children or youth and to keep in mind that children are doing the best they can with the circumstances they’ve got.

Problematic behaviors and symptoms will not always show up immediately following traumatic events. It may take many years for symptoms of traumatic experiences to become apparent. It is not uncommon for adolescence to be a time when childhood trauma is revealed in physiological and/or behavioral symptoms. Individual responses vary widely, so it is important to carefully and compassionately assess symptoms and behaviors through a trauma-informed lens even if nothing obviously traumatic has happened recently in the child’s life.

**Trauma and Resilience**

Unaddressed trauma significantly increases the risk of mental health concerns, substance use disorders and chronic physical diseases. These potential outcomes can be mitigated by resilience. Resilience is comprised of three interactive influences:

1. Individual differences in temperament and cognitive abilities
2. Quality of social relationships—does the child have peers and adults they can trust and who care about them?
3. Quality of the broader environment, such as school and neighborhood

Resilience can be noticed, heightened, and centered by the use of a strengths-based approach to work with children and families. Focusing on the assets and tools that individuals already possess rather than perceived deficits can empower individuals and minimize labels and stigmas. Identifying and building on the strengths of the individual, their support network, and their environment increases resilience and can improve the protective factors in dealing with past and potential future trauma and help to mitigate negative effects from stress.

**Negative Effects of Trauma**

Examples of negative effects include limited or disrupted ability to:

- cope with the normal stresses and strains of daily living,
- form relationships or may not be able to trust in or benefit from them,
- manage cognitive processes (such as memory, attention, thinking),
- regulate behavior, or
- control the expression of emotions.
These negative effects can sometimes take the form of anger, violence, self-harm, distrustfulness, hypervigilance, numbness, substance use, nightmares, avoidance, and/or hopelessness and they can wear a person down physically, mentally, and emotionally. Neurobiology and ongoing health and well-being may be permanently altered. Survivors of trauma have also highlighted the impact of these effects on spiritual beliefs and the capacity to make meaning of these experiences.

You may have noticed that all these symptoms resemble symptoms commonly associated with mental or behavioral health diagnoses. Trauma and mental health often overlap. Trauma can have negative effects on a child’s psychology and, conversely, mental health issues can increase vulnerability to trauma. Trauma should be considered at all points in mental health and substance use services including prevention, treatment, and recovery.

**Trauma and Substance Use**

Interrelated and risks go both directions.

- Substance use as an attempt to manage trauma symptoms (self-medicating theory).
- Trauma occurs as result of substance use and may be more likely (young people using substances are more likely to engage in risky behaviors and be near potentially abusive or dangerous people, may be required to do illegal things to support addiction, etc.).
- Similar patterns and dysregulation in addiction and traumatic stress.

Prioritize integrated and specialized services

- These can be challenging to locate, but are a required component of MediCal via EPSDT (see MHSUDS Information Notice 16-063 in the Supplemental Materials).
- Integration and resource-sharing can occur on treatment team.
- Acknowledging trauma and its relationship with substance use can be an empowering aspect of treatment and recovery.

Youth may engage in risky behaviors as a result of use and experience a traumatic event and/or may be less able to cope with a traumatic event due to substance use than their non-using peers. Some services won’t accept folks who are using drugs or alcohol into their mental health/trauma services, and PTSD is sometimes an exclusion criterion for substance use treatment.

Treatment teams with professionals from both areas can help make sure the services are complimentary.

**Trauma-Informed Tools and Services**

The trauma-informed approach is of particular importance when we are discussing mental and behavioral health interventions. Often, the signs and symptoms of trauma can resemble those of mental illness or behavior disorders. These symptoms and behaviors might then be treated as a mental illness and/or with psychotropic medications, thus causing missed opportunities to address the trauma as well as increasing the likelihood of adding undue stress or even re-traumatizing the individual.

When assessing children and youth for services, a trauma-informed approach is important because:

- Symptoms can be coping mechanisms or adaptive responses.
- Careful assessment is crucial to effective treatment.
- The longer traumatic stress goes untreated, the greater the risk of developing maladaptive and potential dangerous coping mechanisms.
- Symptoms used to find diagnoses often overlap with symptoms/behaviors resulting from trauma.
### Symptoms that Overlap: Child Trauma and Mental Illness

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Attention deficit/hyperactivity disorder (ADHD)</strong></td>
<td>Restless, hyperactive, disorganized, and/or agitated activity; difficulty sleeping, poor concentration, and hypervigilant motor activity</td>
</tr>
<tr>
<td><strong>Oppositional defiant disorder (ODD)</strong></td>
<td>A predominance of angry outbursts and irritability</td>
</tr>
<tr>
<td><strong>Anxiety disorder (incl. social anxiety), obsessive-compulsive disorder (OCD), generalized anxiety disorder (GAD), or phobia</strong></td>
<td>Avoidance of feared stimuli, physiologic and psychological hyperarousal upon exposure to feared stimuli, sleep problems, hypervigilance, and increased startle reaction</td>
</tr>
<tr>
<td><strong>Major depressive disorder (MDD)</strong></td>
<td>Self-injurious behaviors as avoidant coping with trauma reminders, social withdrawal, affective numbing, and/or sleeping difficulties</td>
</tr>
<tr>
<td><strong>Bipolar Disorder</strong></td>
<td>Hyperarousal and other anxiety symptoms mimicking hypomania; traumatic reenactment mimicking aggressive or hypersexual behavior; and maladaptive attempts at cognitive coping mimicking pseudo-manic statements</td>
</tr>
<tr>
<td><strong>Panic Disorder</strong></td>
<td>Striking anxiety and psychological and physiologic distress upon exposure to trauma reminders and avoidance of talking about the trauma</td>
</tr>
<tr>
<td><strong>Substance Abuse Disorder</strong></td>
<td>Drugs and/or alcohol used to numb or avoid trauma reminders</td>
</tr>
<tr>
<td><strong>Psychotic Disorder</strong></td>
<td>Severely agitated, hypervigilance, flashbacks, sleep disturbance, numbing, and/or social withdrawal, unusual perceptions, impairment of sensorium and fluctuating levels of consciousness.</td>
</tr>
</tbody>
</table>

Activity: Small Group Discussion

1. What are some examples of a child's resilience in the face of trauma? Or a time when a strengths-based approach was used successfully to address trauma?

2. Do you or does anyone in your group use formal trauma assessments or other trauma-specific tools? What about trauma-informed service providers?

If so, how are they used? What are the successes and challenges of having this information and approach?

If not, do you think it would be useful to have these tools? How would you use them? How can you get them in your county/agency?

Supplemental Materials:

- SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach
- American Academy of Pediatrics Helping Foster and Adoptive Families Cope with Trauma
- National Registry of Evidence-Based Programs and Practices Behind the Term: Trauma
- National Child Traumatic Stress Network's Trauma and Substance Abuse
- National Child Traumatic Stress Network’s Tips for Finding Help
- Chadwick Trauma-Informed Systems Project: Essential Elements
Segment 5: Accessing Services

Person-Centered Approach

Because trauma and strengths are so unique to each individual, assessment and treatment planning require the use of a Person-Centered Approach. This approach can be defined as:

“a highly individualized comprehensive approach to assessment and services that is founded on an understanding of the person’s history, strengths, needs, and vision of his or her own recovery and includes attention to issues of culture, spirituality, trauma, and other factors.”

For children and youth in foster care, some other factors to observe are grief and loss, sexual orientation, gender identity and expression, and anything else that the child or youth tells you is important. This approach shares the planning, development, and monitoring of services with the person for whom the services are intended.

Accessing Services

All children and youth in foster care are eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). The EPSDT Program is a comprehensive benefit package within Medicaid specifically for children up to age 21. It includes:

• medical,
• dental,
• substance use disorder treatment, and
• mental/behavioral health care services.

All children involved with the foster care system are eligible for federal Medicaid benefits, which is called Medi-Cal in California. The EPSDT Program emphasizes prevention and early intervention, and requires that children receive comprehensive examinations to identify and address treatment needs.

Children and youth who meet medical necessity criteria are eligible to receive Specialty Mental Health Services (SMHS). According to the Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice 16-061, in order to receive SMHS, children and youth must have a covered diagnosis—listed below—and meet the following criteria:

1. Have a condition that would not be responsive to physical health care based treatment; and

2. The services are necessary to correct or ameliorate a mental illness and condition discovered by a screening conducted by the Managed Care Plan, the Child Health and Disability Prevention Program, or any qualified provider operating within the scope of his or her practice, as defined by state law regardless of whether or not that provider is a Medi-Cal provider.

Covered diagnoses are:

• Pervasive Developmental Disorders, except Autistic Disorders
• Disruptive Behavior and Attention Deficit Disorders
• Feeding and Eating Disorders of Infancy and Early Childhood
• Elimination Disorders
• Other Disorders of Infancy, Childhood, or Adolescence
• Schizophrenia and other Psychotic Disorders, except those due to a General Medical Condition
• Mood Disorders, except those due to a General Medical Condition
• Anxiety Disorders, except those due to a General Medical Condition
• Somatoform Disorders
• Factitious Disorders
• Dissociative Disorders
• Paraphilias
• Gender Identity Disorder
• Eating Disorders
• Impulse Control Disorders Not Elsewhere Classified
• Adjustment Disorders
• Personality Disorders, excluding Antisocial Personality Disorder
• Medication-Induced Movement Disorders related to other included diagnoses.

Excluded diagnoses (those for which the MHP is not responsible):
• Mental Retardation
• Learning Disorders
• Motor Skills Disorder
• Communication Disorders
• Autistic Disorders (Other Pervasive Developmental Disorders are included)
• Tic Disorders
• Delirium, Dementia, and Amnestic and Other Cognitive Disorders
• Mental Disorders Due to a General Medical Condition
• Substance-Related Disorders
• Sexual Dysfunctions
• Sleep Disorders
• Antisocial Personality Disorder

Other mental health services available through Medi-Cal:
• Therapeutic Behavioral Services/Coach
• Intensive Care Coordination
• Intensive Home-Based Services
• Therapeutic Foster Care
In California, “non-specialty” mental health services may be provided by a county’s Managed Care Plan. “Specialty” mental health services, mandated EPSDT, are provided (or arranged to be provided) through the county Mental Health Plan. Below are the target populations and services covered by each.

### Medi-Cal Mental Health and Substance Use Disorder Services (MHSUDS) Delivery Systems

#### Target Populations and Services

**Medi-Cal Managed Care Plans (MCP)**

**Target Population:**
Children and adults eligible for outpatient non-specialty mental health services (mild to moderate conditions)

**Non-Specialty Mental Health Services**
- Mental Health Services
  - Individual and group mental health evaluation and treatment (psychotherapy)
  - Psychological testing when clinically indicated to evaluate a mental health condition
  - Outpatient services for monitoring drug therapy
  - Outpatient laboratory, medications, supplies, and supplements
  - Psychiatric consultation
- Alcohol Abuse Services
  - Screening, Brief Intervention, and Referral to Treatment

**County Mental Health Plan (MHP)**

**Target Population:**
Children and adults with disabling conditions that require mental health treatment (children; adults w/ severe cond.)

**Medi-Cal Specialty Mental Health Services**

**Outpatient Services**
- Mental Health Services (assessments, plan development, therapy, rehabilitation and collateral, medication support)
- Day Treatment services and rehabilitation
- Crisis intervention and stabilization
- Targeted Case Management
- EPSDT specialty mental health services

**Inpatient Services**
- Acute psychiatric inpatient hospital services
- Psychiatric Health Facility services
- Psychiatric Inpatient Hospital Professional Services if the beneficiary is in a FFS hospital

### Rights of Medi-Cal beneficiaries

All families with children who are assessed for services under EPSDT should receive a Notice of Action informing them of the results of that assessment. The NOA may be delivered to the child welfare worker, and should be shared with the family and the treatment team.

All county mental health plans must have a toll-free number (listed below).

Beneficiaries have a right to receive:
- A handbook that outlines how to file a grievance and/or an appeal and what services are available to them, and
- An electronic version of a provider directory with contact information.

### Denied Services

If necessary services are denied, terminated, reduced, or delayed an appeal may be filed. Contact your county’s MHP or the Health Consumer Alliance at 888.804.3536 or www.healthconsumer.org.
Core Practice Model
Mental/Behavioral Health Screening Flow

Child Welfare conducts
Behavioral Health Screening
Intake and Annually

- Emergency Needs
  - Child Welfare refers to County Mental Health for WIC 5150 Evaluation
    - Yes
      - Behavioral Health notifies legal guardian and arranges assessment
    - No
      - Behavioral Health meets with Child and Family Team to stabilize and safety plan

- Non-emergency Needs
  - Child and Family Team determines best assessment. ANY qualified MediCal clinician can assess.
    - Then, county MHP or Managed Care arrange for/provide services.
    - Monitor and Evaluate regularly

- No Current Behavioral Health Needs
  - Screen again at least annually

NOTE: Children and youth who are assessed under EPSDT should receive a Notice of Action informing them of the result of the assessment.
If denied services, the caregiver can file an appeal.
Informal Services

Informal Mental Health Services are activities deliberately introduced to help promote healing and alleviate symptoms and to provide the child or youth opportunities for:

- positive peer interaction,
- self-discipline,
- tolerance for frustration,
- enhanced self-esteem,
- mastery of skills,
- being part of something larger than their own current circumstance.

They can also provide a supportive adult who may become a member of the treatment team or can offer insight to the team, like a coach or instructor.

Some informal mental health services that the team may choose to include in a child’s treatment plan are the following:

- Exercise or participation in organized or informal sports,
- Musical training like music lessons, choir, or band
- Art or writing classes or individual artistic expression.
- Participating in community theater productions or drama activities at school
- Interacting with animals can be very therapeutic, as can volunteering to help others.
- Meditation, changes in diet and cooking or participating in food preparation and gardening can all help children manage stress and feel connected.

Involvement in these activities should not be threatened or removed as part of disciplinary actions as they are important to the child’s resilience and well-being.

Use creativity and the unique needs and desires of each individual when developing this portion of the treatment plan. Developing ideas for managing stress and enjoying activities is part of treatment, so the child or youth’s engagement is vital.

Formal Services

Depending upon the needs of the child and the availability of services in the community, the treatment team might consider the following: Medication Support Services; one of the many types of therapy, such as individual, family, or group therapy; medical case management, therapeutic behavioral services; wraparound services; intensive day treatment; or residential care.

All decisions should prioritize the needs of the child above what is merely convenient. A clear line to the goals of the treatment plan should be evident in any intervention selected.

The American Academy of Pediatrics partners with PracticeWise to create a yearly list of evidence-based psychosocial interventions. They rank the interventions based on the quality of the research evidence that supports their effectiveness.

Mental health interventions might be incorporated into a treatment plan with or without accompanying medication.
<table>
<thead>
<tr>
<th>County Mental Health Plan</th>
<th>Phone Number(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alameda (and City of Berkeley)</td>
<td>(800) 491-9099</td>
</tr>
<tr>
<td>Alpine</td>
<td>(800) 318-8212</td>
</tr>
<tr>
<td>Amador</td>
<td>(888) 310-6555</td>
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<td>Butte</td>
<td>(800) 334-6622</td>
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<tr>
<td>Calaveras</td>
<td>(800) 499-3030</td>
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<td>Colusa</td>
<td>(888) 793-6580</td>
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<tr>
<td>Contra Costa</td>
<td>(888) 678-7277</td>
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<tr>
<td>Del Norte</td>
<td>(888) 446-4408</td>
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<td>El Dorado</td>
<td>(800) 929-1955</td>
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<td>Fresno</td>
<td>(800) 654-3937</td>
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<td>Glenn</td>
<td>(800) 507-3530</td>
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<td>Humboldt</td>
<td>(888) 849-5728</td>
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<td>Imperial</td>
<td>(800) 817-5292</td>
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<tr>
<td>Inyo</td>
<td>(800) 841-5011</td>
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<td>Kern</td>
<td>(800) 991-5272</td>
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<td>Kings</td>
<td>(800) 655-2553</td>
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<td>Lake</td>
<td>(800) 900-2075</td>
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<tr>
<td>Lassen</td>
<td>(888) 530-8688</td>
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<tr>
<td>Los Angeles – Tri City</td>
<td>(800) 854-7771</td>
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<tr>
<td>Madera</td>
<td>(888) 275-9779</td>
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<td>Marin</td>
<td>(888) 818-1115</td>
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<tr>
<td>Mariposa</td>
<td>(888) 549-6741</td>
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<tr>
<td>Mendocino</td>
<td>(800) 555-5906</td>
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<tr>
<td>Merced</td>
<td>(888) 334-0163</td>
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<td>County Mental Health Plan</td>
<td>Phone Number(s)</td>
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<tr>
<td>Modoc</td>
<td>(800) 699-4880</td>
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<tr>
<td>Mono</td>
<td>(800) 687-1101</td>
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<td>Monterey</td>
<td>(888) 258-6029</td>
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<td>Napa</td>
<td>(800) 648-8650</td>
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<td>Nevada</td>
<td>(888) 801-1437</td>
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<tr>
<td>Orange</td>
<td>(800) 723-8641</td>
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<tr>
<td>Placer</td>
<td>(888)886-5401 main line</td>
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<td>(866) 293-1940</td>
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<tr>
<td>Plumas</td>
<td>(800) 757-7898</td>
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<tr>
<td>Riverside</td>
<td>(800) 706-7500</td>
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<td>Sacramento</td>
<td>(888) 881-4881</td>
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<td>San Benito</td>
<td>(888) 636-4020</td>
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<td>San Bernardino</td>
<td>(888) 743-1478</td>
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<td>San Diego</td>
<td>(888) 724-7240</td>
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<td>San Francisco</td>
<td>(888) 246-3333</td>
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<td>San Joaquin</td>
<td>(888) 468-9370</td>
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<td>San Luis Obispo</td>
<td>(800) 838-1381</td>
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<tr>
<td>San Mateo</td>
<td>(800) 686-0101</td>
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<tr>
<td>Santa Barbara</td>
<td>(888) 868-1649</td>
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<tr>
<td>Santa Clara</td>
<td>(800) 704-0900</td>
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<tr>
<td>Santa Cruz</td>
<td>(800) 952-2335</td>
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<tr>
<td>Shasta</td>
<td>(888) 385-5201</td>
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<tr>
<td>Sierra</td>
<td>(877)-332-2754</td>
</tr>
<tr>
<td>Siskiyou</td>
<td>(800) 842-8979</td>
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<tr>
<td>Solano</td>
<td>(800) 547-0495</td>
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<tr>
<td>County Mental Health Plan</td>
<td>Phone Number(s)</td>
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<tr>
<td>Sonoma</td>
<td>(800) 870-8786</td>
</tr>
<tr>
<td>Stanislaus</td>
<td>(888) 376-6246</td>
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<tr>
<td>Sutter/Yuba</td>
<td>(888) 923-3800</td>
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<tr>
<td>Tehama</td>
<td>(800) 240-3208</td>
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<tr>
<td>Trinity</td>
<td>(888)624-5820</td>
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<tr>
<td>Tulare</td>
<td>(800) 320-1616</td>
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<tr>
<td>Tuolumne</td>
<td>(800) 630-1130</td>
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<tr>
<td>Ventura</td>
<td>(866) 998-2243</td>
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<tr>
<td>Yolo</td>
<td>(888) 965-6647</td>
</tr>
</tbody>
</table>

Supplemental Materials:

- Mental Health & Substance Use Disorder Services Information Notice No. 16-063: Substance Use Disorder (SUD) Treatment Services for Youth in California
- Mental Health & Substance Use Disorder Services Information Notice No. 16-061: Clarification on Mental Health Plan Responsibility for Providing Medi-Cal Specialty Mental Health Services
<table>
<thead>
<tr>
<th>Mental/Behavioral Health Services Brainstorming Form</th>
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<tr>
<td>County or Agency:</td>
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<tr>
<td>County MHP Provider’s Name and Contact Info:</td>
</tr>
<tr>
<td>Other Useful Partners’ Names and Contact Info:</td>
</tr>
<tr>
<td>Agency strengths and resources:</td>
</tr>
<tr>
<td>What gaps/needs are left after considering these strengths and resources?</td>
</tr>
<tr>
<td>What <strong>informal</strong> treatment options are available to children and youth served by your agency?</td>
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<tr>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What <strong>formal</strong> treatment options are available to children and youth served by your agency?</th>
<th>Are these options culturally sensitive? Trauma-informed? Diverse?</th>
<th>What formal treatment options do you wish you had access to for your children and youth?</th>
</tr>
</thead>
<tbody>
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</table>

What can you do to increase the quality and diversity of treatment options? Who can you ask to help develop needed resources/services? Can you partner with another agency/entity already engaged in this work?

What is your next step?
Segment 6: Psychotropic Medication

Foster Youth Mental Health Bill of Rights

1. Foster youth have the right to receive mental health services and supports.
2. Foster youth have the right to receive information about their mental health, including their diagnosis and available treatment options, in a way that is easy to understand and age appropriate.
3. Foster youth have the right to participate in decisions made about what mental health treatments, services, and medications they receive.
4. Foster youth have the right to receive needed mental health services and supports in a timely fashion.
5. Foster youth have the right to receive mental health services and supports in the least restrictive environment appropriate to meet their individual needs.
6. Foster youth who are twelve or older have the right to privately seek and consent to outpatient mental health counseling and treatment (except for psychotropic medications).
7. Foster youth have the right to take only medication or other chemical substances that are authorized by a doctor.
8. Foster youth have the right to be informed about the risks and benefits of psychotropic medications in an age appropriate manner.
9. Foster youth have the right to tell their doctor that they disagree with any recommendation to prescribe psychotropic medication.
10. Foster youth have the right to go to the judge and say they disagree with any recommendation to prescribe psychotropic medications. *(Foster youth are encouraged to talk to their attorney first to make sure the youth does not say something against his or her interests.)*
11. Foster youth have the right to ask for mental health services, including re-assessments regarding their diagnoses and their prescriptions for psychotropic medications.
12. Foster youth have the right to work with their prescribing doctor in order to safely stop taking psychotropic medications.
13. Foster youth who are twelve or older have the right to confidentiality when speaking with their therapist or doctor. With a few limited exceptions, a health care provider must get permission from a foster youth who is twelve or older before sharing confidential medical information with others. *(Foster youth are encouraged to ask their therapist or doctor what information will or will not be kept confidential and who the provider is allowed to share the information with.)*
14. Foster youth have a right to keep their medical information and diagnoses confidential and only shared with those authorized to know this information for the purposes of arranging for, coordinating, and providing health care services and medical treatment to the youth.
15. Foster youth have the right to see and get a copy of their court record.
16. Foster youth who are twelve or older have the right to see and get a copy of their medical and mental health records. *(A foster youth can request his or her mental health records, but if a health care provider determines that seeing these records would be harmful to the foster youth, they can refuse his or her request.)*
17. Foster youth have the right to continue receiving mental health treatment when their placement changes, including when they are moved to a different county.
18. Foster youth who are in foster care on their 18th birthday have the right to continue to receive health care, including mental health services, through Medi-Cal until age 26 regardless of their income level.

The complete *Foster Youth Mental Health Bill of Rights* document with endnotes and best practices is provided with the supplemental materials in this binder.
Psychotropic medication in foster care

- Non-pharmacological interventions are first-line treatment approach. Medication is to be considered only when other options are not sufficient (outside of emergencies).
- Medication can be prescribed after thorough assessment identifies need and clear treatment goals. Keep in mind that it may take more than one meeting/session/clinician to conduct a thorough assessment.
- When necessary, medication is best used:
  o with other supportive interventions and
  o as part of a comprehensive treatment plan
- Respect for the dignity of the child and family is a prerequisite for all treatment.

Science has yet to fully determine the effects that psychotropic medication might have on the developing brains and bodies of children and youth, but it is clear that some side effects can be quite serious and long-lasting (Gleason, Gordon, & Yogman, 2016). Consequently, the decision to use psychotropic medication should be considered very carefully.

Depending upon the symptoms a child is experiencing, there are three general paths for using medication outside of emergencies:

1. Medication might not be used at all in the example of learned defiance or if symptoms are determined to be the result of trauma rather than mental illness.
2. The team may decide to include medication after other interventions were tried but failed to address all the symptoms. Moderate anxiety or depression might be an example of this scenario.
3. Medication may be part of an initial treatment plan, for example, if the child were experiencing severe Attention Deficit Hyperactivity Disorder, acute symptoms of depression, or psychosis.

If the physician and child and family have decided that medication is necessary, it should be used in conjunction with other interventions to support the holistic health of the child except in rare emergency situations. In certain cases, psychosocial interventions are no longer required when they have already been successfully employed, but continuing medication is needed to prevent recurrence of symptoms.

Regardless of what treatment plan is designed, respect for the dignity of the child and family is a prerequisite. All treatment plans should include the input and consent of the child and family, identify and utilize their strengths, aim to increase their resilience, and prioritize their needs.

Informed consent for medication

- Expectations are clearly outlined on pg. 11 of the Guidelines.
- Children and youth are to be included in the consent and assent process to the extent feasible based on their developmental stage.
- Child, family, and caregiver are informed of the risks and potential benefits of:
  ✓ Proposed medication (name, dose, effects), and
  ✓ Alternative treatments including the absence of treatment.
- Thorough discussion of any serious adverse effects to watch for and when and how to contact the prescriber if anything happens.
- Prescribers consult with SW/PO about who can provide legal consent, and release of HIPAA information.
Limits of medication in foster care

Continuum of Care Reform Title 22 makes it clear that psychotropic medications should not be used for the purposes of discipline or chemical restraint. In acute psychiatric emergencies, chemical restraint may be necessary. This should be extremely rare, and very short-term. Additionally, youth are not to be coerced into taking medication as a condition of getting into or staying in a foster care placement. Safe and consistent administration of medicine at the prescribed time, frequency and dosage is a safety issue, and must be addressed in the treatment plan. If safe administration cannot be achieved, the Court should be informed, and medication should be reconsidered until safety concerns have been addressed.

Safe and accurate self-administration of medication is ideal. If it is not possible for the child or youth to administer their meds themselves, it is necessary to assist them. When assisting a child or youth with administration of medication, it is important to consider their preferences regarding how and when he or she would like to take the medicine as long as those preferences are in line with the prescriber’s instructions. Assist only one child at a time outside the presence of other children. This helps protect their privacy and confidentiality as well as potentially reducing stigma and shame that may accompany taking medication. Document the appropriate procedure for administration and every occurrence in the child’s record including date, time, and dose.

Assisting with Self-Administration

Self-administration of medication is the ideal treatment plan. It ensures responsibility and ownership of the process and can help empower young people. Sometimes this will be a simple process; for other youth, it may be more of a challenge. Here are some ideas that may help--

Make sure that the young person you are assisting is aware of and thoroughly understands the prescriber’s instruction and how to get additional information if there is confusion. Go over the plan thoroughly and make particular note of the anticipated effects, both positive—such as symptom relief—and potentially negative—like side effects.

Regularly reiterate the importance of taking the medication according to the instructions. It is not enough to say this once at the beginning. It is important to reinforce this message throughout the course of treatment. In particular, make sure the youth understands that it could be quite dangerous to miss doses or stop taking medication without the support of a doctor. Also, explain that they won’t be able to tell if the medication is working or not unless they take it as instructed, and that they may not get any benefit from the medication at all if it isn’t taken correctly.

Store the medication in a secure location that the youth can access when they need to. There are obvious safety considerations to factor in depending upon the situation, the youth, and the medication. Strive to achieve the most accessible and empowering situation for the youth while continuing to ensure the safety of everyone. It is important to keep track of medication and to be aware when refills are coming up. The Community Care Licensing Division has specific guidelines for group homes and other facilities regarding medication that can be found in the Supplemental Materials section of this segment.
Be creative about supporting youth to stay on schedule. Colorful calendars or pill boxes can help make the process seem less dull or clinical. If the youth is using a cell phone or computer anyway, some helpful tools can support their self-administration. For example, Mango Health is a medication-tracking app that is designed like a game. Participants can earn points for sticking to their schedule, and they can even win real-world prizes, like gift cards, for reaching their goals. MedHelper and MedCoach are two other medication-tracking apps that might help keep youth on track and provide their caregiver and doctor with information about how they are doing. Some youth may even want to keep track of their symptoms and side effects using the notes function within the app itself.

When symptoms improve and the child is feeling better, it can be particularly challenging to keep taking medication. It is very important that the treatment team and the caregiver have regularly scheduled check-ins about symptoms and medication. Young people need support throughout the course of treatment, not only when things are difficult. It is important to listen carefully to what they say about how they feel and what they want when it comes to their own health care. Young people don’t always know what is best for them, but they are always the experts in how they feel. Building a treatment plan that will work best for each specific person requires that they be part of the plan. Every person is unique, so remain open to all the options. Continue asking questions and exploring until you find the right fit.

Finally, schedule regular check-ins with the youth and members of the team about treatment and symptoms. And discuss all changes, not just the target symptoms. Be reliable and consistent.

Risks

Psychotropic medications are associated with an array of possible risks. They vary widely depending upon the age and unique characteristics of individuals who take them. Some of these risks are called side effects, meaning that medication can cause effects other than or in addition to the intended ones.

Individuals have experienced increased suicidal ideation, sleep disturbance, sleepiness and lethargy or difficulty moving around. Some have experienced rapid weight gain leading to obesity and pronounced changes in their blood sugar and metabolism sometimes leading to diabetes. Nervousness, restlessness, and irritability are also common complaints. Headaches and upset stomach or changes in appetite are also possible. All these risks should be made clear to the child and family when treatment decisions are discussed. Children and families cannot make informed decisions without being aware of these potential risks. The California Guidelines direct the prescribing physician to inform the child, family, and others involved in treatment planning about the risks and benefits of the medicine and of other treatment options including the risks and benefits of no treatment.

Rarely, individuals may have adverse reactions that cause serious illness or death. Chronic illness and permanent facial or body tics and tremors do sometimes occur. It is possible for children or youth to become addicted to certain medications, and this risk should be included in decision making. Additional risks are present when medications are not taken according to the instructions. Treatment plans should include details about safe and consistent administration of the medication, ensuring an adequate supply of medication, and a safety plan for how to stop taking the medication should that be necessary.

There are apps that can help with self-administering medication:
- Mango Health
- MedHelper
- MedCoach
Substance Use and Medication

Careful consideration of the child's overall health and needs is crucial to creating an effective treatment plan. If the child or youth uses un-prescribed medications, other drugs, or alcohol, it is important to assess the risk of adding a psychotropic medication. Interactions between medications and drugs or alcohol can be powerful and toxic. Sometimes, individuals are using drugs or alcohol to self-medicate and to essentially treat the same symptoms that the treatment plan is attempting to address.

Alternatively, substance use disorder itself can mimic the signs or symptoms of other dysregulations. If that is the case, that disorder must be treated first in order to accurately diagnosis the child or youth. If both substance use disorder and other behavioral health issues are present, dual diagnosis treatment should be prioritized in the treatment plan. This means treatment that focuses on the intersection and overlap of problematic substance use and serious mental health needs.

Potential benefits

The best treatment plan for an individual may incorporate medication, which has the potential to improve school performance and ability to concentrate, decrease the experience of anxiety or worry, reduce symptoms of depression, improve or eliminate frequent physical pain or somatic complaints, reduce or eliminate nightmares and other sleep disturbance, and limit excessive aggression or temper tantrums and improve mood.

These potential benefits are to be weighed against the potential risks when deciding whether or not to include medication in a child or youth’s treatment plan.

For children and youth in foster care, not all of these potential benefits are fully backed by evidence (American Academy of Pediatrics, xxx). Therefore, it is vital that the introduction of medications is incremental; beginning with a low dose, and slowly adjusted while carefully tracking any positive or negative effects.

It is important to note that all the benefits described here are also potentially achievable without the use of psychotropic medication depending on the individual. Care must be taken to refrain from viewing pharmaceuticals as the only option or as a cure-all for everyone.

Attention Deficit and Anxiety/Depression Medications

Attention Deficit and Hyperactivity Disorder or ADHD: A relatively common diagnosis for children and youth. Psychomotor stimulants like Ritalin and Adderall are often prescribed to treat the symptoms of ADHD. They can help children to concentrate and control hyperactivity. Common side effects include decreased appetite or stomach discomfort and poor sleep. Non-stimulants such as Strattera have the same benefits as well as decreased compulsive behaviors. The common side effects are also similar—stomach discomfort and poor sleep along with headache.

Anxiety and Depression: Symptoms related to anxiety and depression may also be addressed with medication. Selective Serotonin Reuptake Inhibitors and Atypical Antidepressants such as Prozac, Zoloft, Celexa, Wellbutrin or Lexapro may decrease depressive symptoms, improve mood, and decrease anxiety. They can cause nausea, and disturb sleep. They also pose an increased risk of seizure and an increased risk of suicidal ideation especially in adolescents. These side effects may increase with irregular administration, so should be carefully considered if proper administration is difficult or unlikely.
Mood and Psychotic Disorder Medications

Mood disorders: To address the symptoms of mood disorders such as Bipolar Disorder, doctors prescribe mood stabilizers like Lithium or Anticonvulsants like Depakote. These medications may improve or stabilize mood symptoms and improve impulse control. Lithium can cause dry mouth, tremor, stomach discomfort, weight gain, memory problems, thyroid and kidney problems. Anticonvulsants also have serious potential side effects such as drowsiness, nausea, serious rashes, liver problems. Periodic lab tests and careful monitoring by a physician is necessary while children or youth are taking these medications.

Psychotic disorders: Antipsychotic medications are a potent class of psychotropic medications. They are divided into two categories, Newer and Older. They are used to treat very serious symptoms such as hallucination, delusions, and disordered thinking. They can cause extrapyramidal side effects (EPS) such as shakiness, drooling, and stiffness. They often cause rapid weight gain, heart and blood irregularities, permanent tics and tremors, and diabetes.

Medications to address side effects

Many psychotropic medications have the potential to cause sleep disturbance. Doctors may prescribe sedatives or hypnotics, and sometimes sleep-promoting medications like Benadryl to help children sleep. These medications have the potential to be habit-forming and can cause additional side effects.

The severe side effects from antipsychotics can be treated with anticholinergic medications. These can reduce the shakiness, drooling, and stiffness associated with EPS.

It is important to note that multiple medications and using medication to treat side effects of other medication is not recommended practice, but does occur. Children with several simultaneous prescriptions are at increased risk for adverse effects. Use of multiple medications should be carefully monitored by the family and the physician. As with all medication, these decisions should be carefully analyzed by the entire treatment team to ensure best outcomes for the child.

Side Effects

Safety: If side effects are suspected or identified, safety is the priority. Follow all emergency medical procedures if necessary, and take necessary steps to ensure the safety of the child.

- Consult with the prescribing physician immediately to determine if changes need to be made.
- Do not allow the child/youth to simply stop taking medication. There is usually a protocol for weaning off psychotropic medications, and it is vital to follow those directions.
- If dose or schedule changes, follow up with the required Court documents and document the change in the health record and the child’s file.

Plan ahead: Find out what side effects are possible when the treatment plan with medication is made. Have a safety plan created in the event that side effects emerge. It is important to be aware if there are any known interactions with other drugs or alcohol as well as steps to take that might reduce the likelihood of side effects.

- Appendix B of the CA Guidelines is the primary document CDSS has identified for reference about specific medications and the parameters for their use (dosage, side effects, potential interactions, etc.) LA County is keeping this document up-to-date and publicly available on their website.
• You can learn more about possible side effects by researching on sites like medlineplus.gov or finding the package insert for the prescribed medication, which are usually available online.

**Documenting Side Effects**

• Social workers and probation officers must ensure that monitoring occurs. It may be the PHN or caregiver who do specific tasks, but the social worker is responsible for making sure it happens as often and thoroughly as necessary.

• Social workers and probation officers don’t need to be the experts in knowing all the details of this information, but they must collect it from the doctors and health professionals who are experts and make sure that the child and caregiver and family have received the information and understand it.

• Regularly ask the child or youth to describe their experiences—both physical and emotional—since taking the medication. Ask them to compare those experiences to how they felt before taking medication. This assessment should occur throughout the duration of the treatment as side effects can develop at any time.

• If developmentally appropriate, the child should be aware of effects to watch out for and who they should tell if they experience something new.

• The prescribing physician should make clear to the treatment team how they can be contacted should something arise.

• The recommended dose should be age appropriate. This may be difficult to determine as the FDA has not approved many of the common psychotropic medications for use with children or youth.

• Appendix A of the California Guidelines has age parameters. Even if the dose falls within acceptable guidelines, it may be too much or too little for a specific individual, so it is important to monitor their responses.

• It is also important to check with the family and caregivers of the child or youth to see whether they have noticed any changes in the child’s mood, behavior or appearance. School personnel, friends from church and the community may also be able to identify if there are changes in the child’s behavior in these other environments.

• Collective vigilance and frequent communication can help identify and address side effects from psychotropic medications.

**Supplemental Materials:**

- Foster Youth Mental Health Bill of Rights
- Questions to Ask About Medications Brochure
- Alameda County Transition-Age Youth Side Effect Informational Cards
- American Academy of Child and Adolescent Psychiatry—Facts for Families: Weight Gain from Medication, Prevention and Management
- Medication Monitoring Checklist
- Community Care and Licensing Resource Guide to Medications in Group Homes
- Sample Safety Plan
Activity: Quick Role Play

1. Six-year-old Elizabeth has recently been prescribed Ritalin to address restlessness. Her treatment plan calls for evaluation of symptoms and side effects.

2. Julius is 17 years old and about to transition out of foster care. He currently takes a Selective Serotonin Reuptake Inhibitor (Celexa) for acute anxiety. His foster mother is concerned that he will stop taking it once he leaves her home, and would like him to have a safety plan.

3. After her appointment with the doctor, Phoebe has some questions about the risks and benefits of taking the antipsychotic (Zyprexa) that her doctor is requesting from the court to address her impulsivity and aggression. She is 15 years old and lives in a group home.

4. Charlotte is ten years old and she has been to see her therapist weekly for three months and is taking Vistaril to help her sleep. She feels that her sleep is better, but the therapy is making things worse, and the conversations she has make her more upset. She wants to stop going.

5. Derrick is a foster parent. He was told by the doctor at his foster son’s latest appointment that Adderall does not have any side effects. His eight-year-old foster son was already taking it when he came to Derrick’s home.

6. The Application for Sam to start taking Zoloft to address symptoms of severe depression was approved by the court. Discuss the risk of suicidal ideation related to this drug and decide about safety planning. Sam is 13 years old.
Segment 7: Using the California Guidelines

What are the Guidelines?

The California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care is a detailed document and four appendices that were created and assembled collaboratively by CDSS and DHCS.

- Shared values, expectations, and principles of psychotropic medication use in foster care.
- Designed to be an advocacy tool to help guide non-medical professionals when working with doctors and psychiatrists and other medical personnel or service providers.

Several important goals:

- Increased visibility of strengths and needs of children and youth with emotional, cognitive, and/or behavior dysregulation
- Reduction of social stigma due to dysregulation
- Promoting best practices in the state’s commitment to provide both formal and informal mental/behavioral health services to children and youth in care.

Outlines expectations about:

- Treatment plans, assessment, and diagnosis
- What prescribers should consider for certain activities
  - Before prescribing
  - When prescribing
  - When evaluating whether or not a treatment is effective
  - Prescribing in an emergency

Four Appendices with tools:

A: Prescribing Standards by Age Group
B: Parameters for dose range and schedule (LA County’s Parameters 3.8)
C: Challenges in Diagnosis and Prescribing including recommendations
D: Decision Tree for Prescribing

Principles and Values

The Guidelines outline the shared principles and values of CDSS and DHCS regarding the use of psychotropic medication with children and youth in foster care.

- Always to promote safety, permanence, and well-being
- Real partnerships with the important people in the child’s life
- Working from a child-centered, strength-based perspective to create truly individualized treatment
- Providing the highest quality of care that is integrated within the child’s community and in collaboration with any helpful partners.
- Psychotropic medication is not to be employed as the sole intervention (except in extremely rare cases when treatment with medication is successful, but needs to be continued), but rather as part of a robust overall treatment strategy employing both formal and informal interventions.

Treatment Plan

A treatment plan is the detailed description of services, supports, and treatments that will be employed to eliminate or reduce the child or youth’s identified symptoms, emotional distress, and/or problematic...
behaviors. It is the document that describes how the team will attempt to improve things for the child. Treatment planning is always done collaboratively with children and their families, whether or not a Child and Family Team is created. A multi-disciplinary team functions very similarly, or an even less-structured supportive group can be successful in creating a quality treatment plan. The important thing is to incorporate diverse perspectives that build around the unique resources, abilities, strengths, and needs of each specific child and his or her natural support network and community.

If a child is too young, or if there are developmental or protective issues in the case that prevent collaboration, every effort should be made to involve a representative to speak on behalf of the child in decision making meetings. To every extent possible, the child or their representative should be included in all the planning, review, and re-assessment of the treatment plan.

According to the best practice outlined in the Guidelines, treatment plans include the following:

- The child’s diagnosis and/or outline of emotional/cognitive/behavioral dysregulation based on the child’s history of abuse, neglect, and/or removal from the home;
- A description of the child’s baseline strengths and needs;
- Target symptoms as agreed to by the child, family, and team members and expressed in clear, everyday language;
- Short- and long-term treatment goals;
- Interventions, including evidence-supported treatments, psychosocial interventions, substance abuse prevention or treatment, case management, informal mental health services, educational or behavioral services, extracurricular and recreational activities with start dates and anticipated duration; and
- A clear and specific plan for periodic review and reassessment. Katie A. plans must be reviewed at least every 90 days.
- Updated medication treatment plans must be communicated as an attachment to the JV220 form for the court, as well as shared with the child/youth, family, caregiver, and child welfare social worker and/or probation officer for distribution to all necessary parties in accordance with HIPAA.

These are the basics of high-quality treatment planning. Plans should seek to utilize a variety of interventions to address the root causes of dysregulation whether that cause is trauma or mental illness or a complex interaction of multiple factors. Alleviation of specific symptoms is important, but is only PART of a comprehensive treatment plan. Including interventions that are backed by evidence is crucial. Plans should seek to be comprehensive and treat the whole child not simply the perceived “problems” with the child’s behavior or functioning. HIPAA compliance is as important in treatment planning as it is in all areas of health care.

**Needs Assessment**

Children who have emotional, cognitive, and/or behavioral dysregulation from trauma, mental health concerns, or for other reasons require and deserve a treatment plan that contains a variety of interventions to alleviate their symptoms and to promote their safety and well-being. The first step in that process, is a high-quality, trauma-informed, child-centered assessment.

As we mentioned before, any assessment of children or youth in foster care should be conducted by a licensed practitioner who is informed about the conditions and effects of trauma. And should thoroughly cover all of these items:

- Physical AND mental status examinations,
• Identification of target symptoms and the goals of treatment,
• A clear plan and timeline for re-assessment and how monitoring progress will occur and who is responsible for which parts of the plan, and
• A clear risk/benefit analysis of each treatment in the plan including the risks and benefits of no treatment

Physical Examination

The results of the most recent physical examination of the child—within the past year—should be reviewed as part of the treatment planning process. These results will be used to rule out medical conditions when they may contribute to or cause the presenting symptoms, and to provide baseline information for monitoring potential side effects. As appropriate, the treatment team may consider a pregnancy test or substance use screen, as both could have serious implications for whether or not to prescribe psychotropic medication. These initial examinations are particularly important for follow-up and monitoring side effects because without a baseline, it may take longer to notice changes that may indicate dangerous developments or side effects that need to be addressed quickly.

Mental Health Examination

The examination of the child’s mental status should be developmentally appropriate. Any applicable diagnosis should be in line with professional standards and be supported by sufficient documentation to rule out other possible diagnoses. The assessment should identify the target symptoms and goals of the selected treatment, along with a timeline for when results should be expected and how long the treatment is intended to last. It is important to share the results of this assessment with the child and their support network, but it is especially important to share the goals and target symptoms with them. In this way, everyone will understand what the treatment is for and what to expect. It is also important to consider if the goals are focused on treating the underlying emotional distress that the child is experiencing, and to refocus them onto alleviating that distress if necessary. Regular re-assessment is an expected activity. The treatment team should monitor symptoms, side effects, and the child and family’s needs and desires. All treatment plans should explicitly incorporate a risk–benefit analysis that compares a treatment plan without medication to the potential benefits and risks of adding a prescription.

Goals and Target Symptoms

Tremendously important to the quality of the treatment plan is to identify specific symptoms that the treatment is intended to address. This is where the voice and opinion of the child is crucial. Treatment plans should not just target the behaviors that a caregiver finds problematic, but attempt to address the core issues and source of dysregulation. Ideally, NOT just medication will be used to reach the goals stated here.

Informed Consent

It is important to obtain informed consent for any and all treatment, not just for medication. The role of the social worker, public health nurse, and/or probation officer is to ensure that the child understands their rights and the risks/benefits of the proposed plan. Use terminology that is clear and easy to understand. Information should be provided in the child and family’s primary language and in written form, if possible.

In California, a child the age of 12 and over has the right to consent to treatment and the right to refuse consent. The assent, or agreement, of children younger than 12 is very important.

The social worker is responsible for knowing who is and who is not able to provide legal consent.
Guidelines for Prescribing

- Start Low, Go Slow—to best monitor effectiveness and side effects, it is important that psychotropic medications are introduced one at a time, and starting from the lowest recommended dose. The dose can be incrementally increased until the lowest effective dose is identified.
- On-label Use—preference should always be given to medications that are FDA approved for the age group, diagnosis, and dose for which it is being prescribed. Medi-Cal has a list of brands and generics that should be used when possible.
- If changes are necessary, they should be made to one medication at a time. It is very difficult to determine what is working and what isn’t if multiple changes take place at once.
- If you think there may be too much in a prescribed dose or too many medications total, talk to a psychiatric specialist at your county. Do not assume that the doctor is right. It’s okay to get a second opinion.

Supplemental Materials:

- *California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care* and Appendices
- All County Information Notice No. 1-0514: Sharing Information with Caregivers
- All County Information Notice No. 1-36-15: Improving Safety for Children in Foster Care Receiving Psychotropic Medications
### Activity: Get Familiar with the Guidelines

1. What page will help you determine the prescribing standards for a child who is 13 years old?

2. What are all the potential complications and side effects for Serotonergic Antidepressants?

3. According to the Guidelines, who is responsible for obtaining informed consent?

4. Sometimes doctors prescribe medication to treat a symptom other than the medication’s indicated use. This is called off label or black box prescription. Where in the Guidelines can you find information about the challenge of off-label or “black box” prescription?

5. What are the three sections of the Prescribing Algorithm (Decision Tree)? Follow-up question, what is Section C actually used for?

6. How do the Guidelines documents connect with the JV-220 process?
Segment 8: Wrap Up and Evaluation

Wrap Up Questions—

• Is there anything missing from the Guidelines that you think might help you with psychotropic medication in foster care?

• What about working from a trauma-informed perspective resonates with you the most?

• What do you need to incorporate this perspective into your work?

• Any remaining questions?

Ombudswoman's Office

If you have any questions or concerns about psychotropic medication in foster care, the Foster Care Ombudswoman of California has agreed to have her contact information included in this training. Her office is available for support and resources on this topic.

Toll-free phone: 1.877.846.1602
E-mail address: fosteryouthhelp@dss.ca.gov

Course Evaluations

Thank you for your time and attention to this important topic.
Resources

- CalSWEC hosts a toolkit for the child welfare/mental health learning collaborative that has an array of training and implementation resources regarding the delivery of behavioral health services to children in foster care. The toolkit also provides contact information for partnering organizations that provide training and technical assistance. The toolkit was designed for use by California counties and regions, and is also accessible by the public: [http://calswec.berkeley.edu/toolkits/child-welfare-mental-health-learning-collaborative-katie](http://calswec.berkeley.edu/toolkits/child-welfare-mental-health-learning-collaborative-katie). Within this toolkit, you may have particular interest in the resources found in the web pages for “Teaming Tools” and “Engagement Tools.”


- Substance Abuse and Mental Health Services Administration’s *Concept of Trauma and Guidance for a Trauma-Informed Approach*, July 2014 [http://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf](http://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf)


- The National Child Traumatic Stress Network’s toolkits [www.NCTSN.org](http://www.NCTSN.org)

- Alameda County Transition-Age Youth and shared decision making tools: [http://www.acbhcs.org/MedDir/decision_tools.htm](http://www.acbhcs.org/MedDir/decision_tools.htm)

- [http://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx](http://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx)

- The California Institute for Behavioral Health Solutions (CIBHS) offers training resources that support Katie A. implementation, including webinars for preparing youth, parents, and professionals for participation in the Child and Family Team (CFT) and team meetings: [http://www.cibhs.org/katie-implementation-technical-assistance-and-training](http://www.cibhs.org/katie-implementation-technical-assistance-and-training)
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