

PRACTICE NOTES

For North Carolina's Child Welfare Workers

From the NC Division of Social Services and the Family and Children's Resource Program

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This publication for child welfare professionals is produced by the North Carolina Division of Social Services and the Family and Children's Resource Program, part of the Jordan Institute for Families within the School of Social Work at the University of North Carolina at Chapel Hill.

In summarizing research, we try to give you new ideas for refining your practice. However, this publication is not intended to replace child welfare training, regular supervision, or peer consultation—only to enhance them.

Let us hear from you!

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PRESCRIPTION DRUGS AND CHILD WELFARE PRACTICE

Prescription drugs are a growing presence in families' lives today. A 2006 survey found that 55% of adults in the U.S. had taken at least one prescription medication in the preceding week; 11% had taken five or more (Slone Center, 2006). For many, prescriptions bring clear benefits, helping people manage and cure diseases and improve their quality of life.

But medicines can bring harm as well. This is particularly true for painkillers. Since 1999 misuse and abuse of powerful opioid pain relievers have grown dramatically, as have overdose death rates and substance abuse treatment admissions (CDC, 2011). More and more, "legal" drugs are being used in ways that are not approved.

In 2010 more than 12 million Americans used painkillers without a prescription or to get high (SAMHSA, 2011).

The bottom line for child welfare practitioners? The presence of prescription drugs in families' lives is something we must be able to assess and, if necessary, address. We aren't medical professionals, so this is something we must do in partnership with physicians, mental health providers, substance abuse counselors, and other experts. But we do have an important part to play. We hope this issue of *Practice Notes* is useful to you as you respond to the challenges sometimes presented by prescription drugs. ♦



FAMILY-CENTERED CPS ASSESSMENTS OF PRESCRIPTION DRUG USE

Given the risks associated with prescription drugs, it can be tempting to focus on uncovering misuse or deceit, rather than working from a family-centered, strengths-based perspective. Guard against this error.

If someone in a family is taking a prescription drug, it is important to first understand what need that person is trying to meet with that drug, and how well it is working for the family as a whole. Whether the prescription is being used correctly or incorrectly, legally or illegally, you will have a hard time helping the family make changes if you don't understand the motivation behind the drug use.

When talking with families, explain why you're asking for certain kinds of information. This can build a foundation of trust and respect if you convey to parents that you are trying to understand the needs of everyone in the family, and to help them meet their needs in the safest and best way possible.

When talking with families about their use of prescription drugs, ask what medication is taken and how often, what need it is

meeting (e.g., fight pain, treat illness), what education was provided by the physician, and whether the parent has concerns about the medicine. Ask how well the drug is meeting the need.

Educate parents through the interview process by sharing information about safety risk factors you see (e.g., drug storage), and by showing parents how to keep medications out of children's reach.

Engage the parent in safety planning. Use strength-based questions to learn about social supports, coping skills, and what's going well for the family.

Ask yourself what risk factors the parent may have for abusing or misusing prescription drugs. Use a brief assessment tool (such as CAGE or UNCOPE) to see if any concerns emerge.

Be prepared with referrals for a substance abuse evaluation if the assessment indicates a potential substance abuse issue.

Support and engagement skills are key.

Child Welfare and Prescription Drug Abuse

ANSWERS TO COMMON QUESTIONS

The following questions are representative of those asked by North Carolina county DSS child welfare staff during an April 19, 2011 webinar on prescription drug abuse. Special thanks to Elizabeth Flemming, MA, LPC, Associate Director, MAHEC Mental Health Education, for her contributions to this article.

1. If a client has a valid prescription, how can I verify misuse?

Only a physician or substance abuse professional can formally diagnose or identify abuse or misuse of prescribed medications. However, as a child welfare professional, you are in an excellent position to screen for the signs of substance abuse/misuse. To do this, look for indications the client's use of prescription drugs is problematic: Does she seem in control of her use of the medicine? Is the quality of her life expanding with the treatment, or constricting? Does she continue to increase her use of the drug in spite of adverse consequences or problems? Does she use the medicine as prescribed? (Scholl & Finch, 1994). Or, use a brief screening tool such as the CAGE or UNCOPE (see sidebar).

If there are signs of a problem, seek the client's written permission to communicate with the prescribing physician, and/or refer the client for an evaluation by a substance abuse professional. Also, the problem may be that the person has pain that is not being adequately addressed; a physician will be able to assess this possibility, and will know how to support the person with appropriate pain management strategies if need be.

2. Is there a way to determine the level of a drug in someone's system? It is prescribed to be taken "as needed" for chronic pain.

Even if you could determine the amount of the drug in the client's bloodstream, the information would probably be meaningless—the client is under a doctor's care and apparently taking the medication as prescribed. It is more useful to look for signs of a problem as described in question 1 above.

3. Is it common for family physicians to prescribe mental health medications?

Yes, many family doctors now prescribe medications to treat mental problems; it is very common in some communities due to a shortage of psychiatrists.

4. Do hospitals and medical offices have a way to flag people who may be abusing drugs?

North Carolina has something called the Controlled Substance Reporting System (CSRS). Established by State law, the CSRS is a prescription monitoring system that allows registered dispensers (pharmacists) and medical

UNCOPE Screening Instrument for Substance Abuse

The UNCOPE consists of six questions found in existing instruments and assorted research reports. Variations in wording are noted for several of the items. The more concrete wording of the revised versions were found to be slightly better as a generic screen. Either version of the six questions may be used free of charge for oral administration in any medical, psychosocial, or clinical interview. They provide a simple and quick means of identifying risk for abuse and dependence for alcohol and other drugs.

- U** "In the past year, have you ever drank or **used** drugs more than you meant to?" or, as revised "Have you spent more time drinking or using than you intended to?"
- N** "Have you ever **neglected** some of your usual responsibilities because of using alcohol or drugs?"
- C** "Have you felt you wanted or needed to **cut down** on your drinking or drug use in the last year?"
- O** "Has anyone **objected** to your drinking or drug use?" Or, "Has your family, a friend, or anyone else ever told you they **objected** to your alcohol or drug use?"
- P** "Have you ever found yourself **preoccupied** with wanting to use alcohol or drugs?" or, as revised, "Have you found yourself thinking a lot about drinking or using?"
- E** "Have you ever used alcohol or drugs to relieve **emotional discomfort**, such as sadness, anger, or boredom?"

For further information on the UNCOPE, contact Norman G. Hoffmann, Ph.D. Evince Clinical Assessments, PO Box 17305, Smithfield, RI 02917, Tel: 800/755-6299; 401/231-2993; evinceassessment@aol.com

practitioners to review a patient's controlled substances prescription history on the web. It is intended to help practitioners monitor, identify, and refer patients for specialized substance abuse treatment or specialized pain management.

All prescriptions for controlled substances (schedule II through V) dispensed in North Carolina are reported into the CSRS database. Pharmacies transmit the data weekly. Prescribers and pharmacists register and are then granted a password to access the system online to look up a patient's controlled substances prescription history. Information in the system dates back to July *cont. p. 3*

2007. Prescribers may legally query the system for their patients only. Participation in the system is voluntary. Currently about 20% of physicians in the state participate in this system, but enrollment is growing.

Ask doctors and hospitals if they participate in the CSRS. In the next few years, expect to see more doctors connected with Medicaid and CCNC (Community Care Network of NC, <http://www.communitycarenc.com>) using this reporting system. To learn more, visit:

- http://www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/ByArticle/Chapter_90/Article_5.html
- <http://www.ncga.state.nc.us/gascripts/statutes/statutelookup.pl?statute=90-113.74>

5. Can I access people’s prescription profiles on the CSRS if I have a HIPPA release?

No. The only people who can access CSRS are prescribers, special agents, and other specific parties. If DSS is working with law enforcement and this is pertinent information in protecting a child, DSS can work with law enforcement to share information as needed from the CSRS.

6. Are doctors who overwrite scripts ever prosecuted?

Doctors are subject to criminal prosecution if they break the law. Although prosecutions and convictions of this kind are uncommon, they do happen. However, in the

vast majority of cases “overwriting” prescriptions is unintentional and due to difficulty communicating with other doctors and a variety of other factors.

7. What is the success rate of Suboxone clinics?

Suboxone is a prescription narcotic drug used to treat opioid dependence. General success rates for Suboxone (or other drug treatment modalities) are not particularly meaningful because each person is different—each person’s vulnerability to addiction is variable. Addiction severity varies. Furthermore, treatment success depends on treatment of other co-occurring conditions (e.g, depression) and environmental factors; stress is a primary relapse predictor.

8. If methadone is used as prescribed, does it affect the caregiver’s ability to parent?

Used as prescribed, methadone does not cause euphoria or intoxication. Instead, it allows people to work and parent, live productive lives, and improve their health (Joseph, 2000; Brady, 2007). For more about methadone and medication assisted drug treatment (MADT), see pages 6 and 7 in this issue. ♦

TrainingMATTERS
 Read the February 2012 issue of *Training Matters* to learn more about child welfare practice with families struggling with substance abuse.

Effects of Specific Substances on Parenting

Opioids	Effects on Parenting
<p>Produce euphoria followed by drowsiness.</p> <p>Representative drug types & names:</p> <p>Oxycodone (OxyContin, Percodan, Percocet); Propoxyphene (Darvon); Hydrocodone (Vicodin, Lortab, Lorcet); Hydromorphone (Dilaudid); Meperidine (Demerol); Diphenoxylate (Lomotil); Morphine (Kadian, Avinza, MS Contin); Codeine; Methadone</p>	<ul style="list-style-type: none"> • May forget or neglect parenting responsibilities. • May leave children alone while seeking, obtaining, or using the drug. • May “nod out” while under the influence and be unable to supervise or protect children. • May expose children to dealers, other users, and hence to unsafe and dangerous situations.
Stimulants	Effects on Parenting
<p>Increase alertness, attention, and energy.</p> <p>Representative drug types & names:</p> <p>Dextroamphetamine/amphetamine (Adderall, Adderall XR)</p> <p>Methylphenidate (Ritalin and Concerta)</p>	<ul style="list-style-type: none"> • Because sleep-wake cycle is severely disturbed, parent may be unable to attend to child’s need for structure. • May become impatient or irritated with a child unable to adapt to parent’s level of energy. • Parent is not hungry due to appetite-suppressive effects and therefore is not preparing meals for herself and may fail to ensure child is fed.
Central nervous system depressants	Effects on Parenting
<p>Produce a drowsy or calming effect.</p> <p>Representative drug types & names:</p> <p><u>Barbiturates</u>: Mephobarbital (Mebaral), Pentobarbital sodium (Nembutal)</p> <p><u>Benzodiazepines</u>: Diazepam (Valium), Alprazolam (Xanax), Lorazepam (Ativan)</p>	<ul style="list-style-type: none"> • May forget or neglect parenting responsibilities. • May leave children alone while seeking, obtaining, or using the drug. • May fall asleep while under the influence and be unable to supervise or protect children.

Adapted from Dore, 1998; Gold, 1992; National Institute on Drug Abuse (NIDA), 2001; NIDA, 2003

PREVENTING ACCIDENTAL POISONING DEATHS

A mother is panicked to find her toddler barely breathing and listless. A child is traumatized when he loses his father to drug overdose.

As accidental drug poisonings surged over the past decade, stories like these have become all too familiar to social workers, emergency responders, and medical providers. When you consider the scope and nature of this problem, it's clear child welfare workers can help prevent accidental overdoses and deaths.

Child welfare workers can help prevent accidental overdoses and deaths.

SCOPE OF THE PROBLEM

Here are some striking national statistics and facts from the Centers for Disease Control and Prevention (2010):

- **We've hit an all-time high.** Death rates from overdose have never been higher. In 2007 there were 27,658 unintentional overdose deaths in the U.S.
- **The rise has been steep.** Between 1999 and 2005 the annual number of unintentional drug overdose deaths in the U.S. more than doubled—from 11,155 to 22,448. Overdose death rates have increased roughly five-fold since 1990.
- **Opioid use has jumped.** There has been at least a 10-fold increase in the medical use of opioid painkillers during the last 20 years due to more aggressive pain management by physicians.
- **More deadly than illegal drugs.** In 2007, the number of deaths involving opioids was 1.93 times the number involving cocaine and 5.38 times the number involving heroin.

Risk of accidental overdose and death is made worse

by the combined use of pharmaceuticals with alcohol or other substances and “doctor shopping,” which occurs when patients obtain prescriptions from multiple physicians with no coordination among the doctors involved. The addictive effects of some prescribed drugs may also increase the likelihood of unintended consequences.

Opioids—synthetic versions of opium—are good candidates for misuse and abuse because they cause euphoria. These drugs are typically prescribed for pain management and can be highly effective, but when taken in excess they can suppress breathing to a fatal degree (CDC, 2010). Challenges faced by patients with opioid prescriptions can include storing the drug safely within the home, negative drug interactions (if they take multiple medications), and the risk of overmedication (if higher than needed dosages are prescribed).

Access to pharmaceuticals for non-medical use also happens through sharing among family or friends, theft, purchase through illicit means, or online vendors who don't require a prescription. This kind of use is especially risky because it occurs without medical oversight.

EDUCATING FAMILIES

The medical community can help reduce the likelihood of overdose by counseling patients about the risk of overdose to themselves and to others (Hall et al., 2008). Child welfare professionals, too, can help by actively educating the families we work with to ensure they have information that will save lives. To prevent ac-

cont. p. 5

Increase in Young Children Accidentally Poisoned with Pharmaceuticals

A 2011 study by Dr. Randall Bond and colleagues gathered data about 544,133 children age 5 years and younger who had visited the emergency department (ED) because they may have been poisoned by medication.

During the study period (2001 to 2008) 95% of ED visits were due to self-ingestion. Prescription drugs accounted for 55% of the ED visits, 76% of hospital admissions, and 71% of significant injuries. The biggest impact came from opioid pain relievers (e.g., oxycodone), sedative hypnotics (e.g., muscle relaxants, sleep aids), and cardiovascular medications.

Though the number of U.S. children under age 5 increased only 8% during the study period, there was a 22% rise in the exposure for this age group. Study authors attribute this increase to a greater availability of, and access to, medications in the home. They note that effective “poison proofing” may have plateaued or declined in recent years.

“Prevention efforts of parents and caregivers to store medicines in locked cabinets or up and away from children continue to be crucial. However, the largest potential benefit would come from packaging design changes that reduce the quantity a child could quickly and easily access in a self-ingestion episode,



More ER visits are due to poison than car accidents for children under age 5.

like flow restrictors on liquids and one-at-a-time tablet dispensing containers,” Dr. Bond suggests.

Bond recommends these changes be applied to both adult and pediatric products and to over-the-counter and prescription products.

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cidental overdose, please share the following lifesaving guidelines (NCDHHS, 2010) with the families you work with:

- Do not use drugs or other illicit substances alone.
- Do not mix drugs; if using opioids, avoid drinking alcohol and taking benzodiazepine.
- Do not use drugs if unsure of their potency.
- Do not use drugs after a period of prolonged nonuse (such as drug rehabilitation or prison).
- Do not use drugs in ways other than prescribed.
- Do not use poly-substances, including dietary and herbal supplements, without consulting a physician.
- Keep medications and chemicals in their original containers and in a safe place.
- Dispose of medications correctly. Most can be disposed of in the trash. The FDA and EPA recommend placing them in sealable containers mixed with an undesirable substance (e.g., cat litter). Some pharmacies will also take back unused medications. Some medications that may be especially harmful to others, such as opioids, may be safely flushed down a drain or toilet.

In addition, all parents, extended family members, foster parents, and others should take these steps to protect children from accidental poisoning:

- Save the Carolinas Poison Center phone number, 1-800-222-1222, in your cell phone.
- Keep all medications and chemicals in childproof cabinets. Don't store poisonous substances near food.
- Do not leave children unsupervised in the vicinity of household products or drugs.
- Do not refer to medications as "candy."
- Identify poisonous plants in your house and yard and place them out of reach of children.

Share this information during home visits, post it visibly within the agency, and add it to the agency website.

Additionally, child welfare professionals can work to improve families' access to a medical professional and to treatment for substance abuse. Knowing that a mental illness or a history of substance abuse can raise the risk for an overdose, help those with these challenges find the critical services for monitoring health and reducing risk factors.

Above all, social workers can bring compassion and concern to families who have experienced the pain of a non-fatal or lethal overdose, and can ensure that the voices of survivors and family members are heard when a community decides how to respond to this complex and challenging public health issue. ♦

POISON RESPONSES FOR CHILD WELFARE STAFF

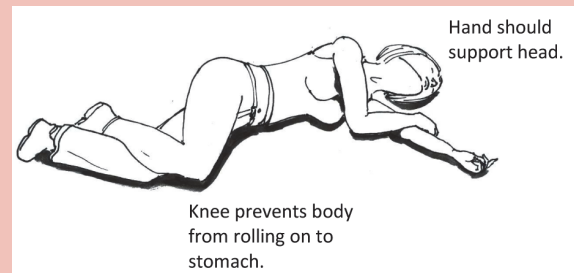
IF A POISONING HAS OCCURRED

- Call 911 if an emergency. Signs of a poisoning emergency include unconsciousness, convulsions, or difficulty breathing.
- Be aware that symptoms of an overdose may not occur immediately. Symptoms may be delayed for up to several days.
- If the patient is responsive, call the Carolinas Poison Center at 1-800-222-1222.
 - Provide the victim's age, weight, time of exposure, name on the poison container or bottle, and address.
- Follow all instructions provided by the specialist.

RESPONDING TO OPIOID AND OTHER UNINTENTIONAL POISONING OVERDOSES

Signs of an overdose

- Skin is pale and/or has a blue tint (cyanosis).
- Difficulty breathing.
- Unresponsive.
- Confusion or disorientation.
- A slow, erratic, or stopped pulse.
- Body is limp.
- Vomiting.



Respond appropriately

- Assess the situation: rub knuckles against the breastbone. If the victim does not react, he/she is unconscious.
- Place victim on his/her side in the recovery position (see illustration).
- If the victim is not breathing, clear airway and provide rescue breathing.
- Dial 911; mention that the victim has had an overdose so that the medical responders will be prepared to respond to the situation appropriately.
- Immediate medical help is the best way to prevent death or disability from an overdose. Potentially life-saving antidotes and/or emergency treatment are available.
- Fear of prosecution should not interfere with calling for emergency help.

Source: NCDHHS, 2010

METHADONE: INTRO FOR CHILD WELFARE WORKERS

In the field of child welfare today there is growing emphasis on evidence-based practice. While we have yet to develop a solid base of empirical evidence for much of what we do in child welfare, there are interventions that have been proven to be effective and which we should embrace. Methadone maintenance—the best known form of medication-assisted drug treatment—is one such intervention.

What is methadone?

Methadone is an opioid medication that is used as a pain reliever and, together with counseling and other psychosocial services, is used to treat individuals addicted to heroin and certain prescription drugs (US Children’s Bureau, 2009). Methadone:

- Blocks the euphoric and sedating effects of heroin and other opiates;
- Relieves the craving for heroin and other opiates that is a major factor in relapse;
- Relieves symptoms associated with withdrawal from heroin and other opiates;
- Does not cause euphoria or intoxication (with stable dosing), thus allowing a person to work and participate in society (APT Foundation, 2010).

What is methadone maintenance treatment?

Methadone maintenance is an outpatient treatment program in which people currently dependent on heroin or other opiates receive a daily dose of methadone (often in liquid form), with counseling and other social and rehabilitation services (APT Foundation, 2010).

How long does treatment last?

Treatment duration should be decided by each individual and his or her physician. Some people leave treatment after a few weeks; others choose to stay in treatment indefinitely. Those who quit after short-term treatment are more likely to return to drug use than those who stay in treatment until they have obtained optimal benefits (SAMHSA, 2009).

Safety

Methadone treatment is medically safe and used even with pregnant women. It creates the same physical dependence, but reduces the deaths, HIV infections, crime, and violence associated with heroin use. It allows people to work and parent, live productive lives, and improve their health (Joseph, 2000; Brady, 2007).

Effectiveness

Studies have shown methadone to be a highly effective treatment for addiction to heroin and other opiates. Methadone maintenance has been endorsed by orga-

WHERE DO YOU STAND?

Would you tell an insulin-dependent diabetic parent that she may not have her children back unless she stops taking insulin and manages her diabetes solely through nutrition and exercise?

Individuals engaged in methadone maintenance treatment can face heavy discrimination within the child welfare system from judges, attorneys, and caseworkers who believe the ultimate goal of treatment should be a completely drug-free individual.

Stopping the methadone treatment, however, leaves the individual at a very high risk for relapse to illicit opiate use and its associated high-risk factors, including unsafe injection practices and illegal behavior in order to support a habit. All of these can significantly increase the risk of abuse or neglect to children in the custody of these parents.

Hence, the decision to require a detoxification from methadone must be considered carefully and based upon sound clinical principles rather than upon the stigma associated with methadone treatment.

Adapted from SAMHSA, 2009

nizations such as the American Public Health Association, NIDA, and others; public health insurance programs, such as Medicaid, often pay for it (Lundgren, et al., 2006).

Do methadone clinics do drug testing?

Yes. Clinics are required to provide drug abuse testing, with a minimum of 8 random urine drug tests per year (Lundgren, et al. 2006).

Impact on parenting capacity

With stable dosing, methadone does not cause euphoria or intoxication. That said, the extent to which any drug will negatively impact someone’s ability to parent depends on a variety of case-specific factors. Assessments of parenting capacity must focus on the needs of children and their parents’ ability to provide for them. Each family should be assessed individually.

Benefits to families and children

Benefits of methadone treatment for opiate addicted parents include improvements in health and employment status and reduced risk of death, HIV, crime, and violence (Kott, et al., 2001). Participation in methadone treatment also has been linked with improved child rearing and reduced involvement with child protective services (Kott, et al., 2001). Methadone can make it possible for families of opiate-dependent mothers to remain together while the mothers receive treatment (Lundgren, et al., 2006). ◆

TIPS FOR WORKING WITH MOTHERS IN METHADONE TREATMENT

The following suggestions for working with mothers on methadone and other forms of medication assisted drug treatment (MADT) are excerpted from a presentation by Lena Lundgren, Nancy Young, Therese Fitzgerald, and Cat Oettinger (2006). Visit this link on the National Center on Substance Abuse and Child Welfare's website to access their full presentation: <http://www.cffutures.org/files/presentations/MedicationAssistedTreatmentAndChildWellBeing.pdf>.

- View participation in methadone or other forms of medication assisted drug treatment as long-term treatment and as a measure of stability, not as long-term drug use.
- Be aware that the methadone is often the primary source of support and stability for these women, and withdrawal can be extremely difficult, physically and emotionally.
 - This is particularly important to consider for clients who also have mental health concerns, and for whom the effects of withdrawal will be even greater.
 - Consult with methadone clinic staff and the client's substance abuse counselor before suggesting that the client withdraw from treatment.
- When assessing your MADT client's needs and risks, identify what services are available to your client through MADT, specifically:
 - What types of services other than the medication are provided at the specific clinic?
 - Does the counseling take place in house, or is it referred out?
 - If the counseling is referred out, does the clinic have a mechanism to follow up and verify whether clients participate in counseling?
 - Is there a psychiatrist on staff?
 - Are there parental support services?
 - Is there a way to collaborate with counselors from MADT settings to develop joint treatment plans? If so, is my client willing to sign a release of information to allow such collaboration?
- Be aware of clinics that work specifically with certain populations, for example, with opiate-dependent pregnant women. These clinics are more likely to:
 - Have the knowledge and services available to work effectively with this population.
 - Be able to assess needs and risks of this population (for example, recognizing an infant with narcotic abstinence syndrome).
- Encourage women to remain in MADT through their pregnancies and after.
 - Pregnant women and new parents face exceptional stress.
 - Few personal, social, and economic resources are available to these women.
 - Ending MADT would have a dangerous effect on the mother and infant, and likely lead to relapse.
- Encourage clients to participate in MADT for as long as the clinic staff recommends.
 - In general, longer participation in treatment leads to better outcomes for both mother and child. These may include:
 - § Abstinence from drugs
 - § Reduced HIV risk
 - § Improved mental health
 - § Improved dental health
 - § Improved physical health
 - § Secure employment
 - § Acquisition of parenting skills
- Collaborate with staff at MADT clinics around issues of child safety and well-being.
 - Clinic staff are frontline observers of these children, and can assess developmental and physical concerns, and concerns of parental abuse or neglect.
 - Clinic staff can make referrals to outside services for these children.
- Provide or make referrals to as many appropriate services as possible.
 - These mothers are faced with many barriers to effective treatment and well-being.
 - Arranging for these services may be helpful:
 - § Stable housing
 - § Employment assistance
 - § Parenting education groups
 - § Couples and/or family counseling (including the children)

Training **MATTERS**

Read the February 2012 issue of *Training Matters* to learn more about methadone and medication-assisted drug treatment.

FOSTER CHILDREN AND PSYCHOTROPIC MEDICATIONS

Reprinted from the *CB Express* (Feb. 2012, v. 13, n. 1), <http://cbexpress.acf.hhs.gov/>

A joint letter to States from the Administration for Children and Families (ACF), the Centers for Medicare and Medicaid Services (CMS), and the Substance Abuse and Mental Health Services Administration (SAMHSA) outlined plans to strengthen oversight of the use of psychotropic medication with children in foster care. The November 23, 2011 letter was sent to each State child welfare director, Medicaid director, and mental health authority and highlighted the overrepresentation of children in foster care using psychotropic medications. While children in foster care represent only 3 percent of children covered by Medicaid, they are prescribed antipsychotic medications at nearly nine times the rate of other children receiving Medicaid.

The letter provided States with background information on the use of psychotropic medication as well as resources for interagency collaboration to strengthen oversight. The three agencies will convene workgroups

in 2012 to help States develop action plans to address this issue.

The letter is available on Children's Bureau's website: www.childwelfare.gov/systemwide/mentalhealth/effectiveness/jointlettermeds.pdf.



RELATED ITEM

In December, Bryan Samuels, Commissioner of the Administration on Children, Youth and Families, testified at a U.S. Senate subcommittee hearing examining the U.S. Department of Health and Human Services' guidelines on the use of psychotropic medication for children in foster care. Commissioner Samuels' testimony is available on the Senate subcommittee's website: <http://www.hsgac.senate.gov/download/samuels-testimony>.

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