Bill as Introduced

7Apr2021... 0517h

HB 120 - AS AMENDED BY THE HOUSE

2021 SESSION

21-0052
05/06

HOUSE BILL **120**

AN ACT relative to administration of psychotropic medications to children in foster care.

SPONSORS: Rep. Marsh, Carr. 8; Rep. P. Schmidt, Straf. 19; Rep. Gay, Rock. 8; Rep. Salloway, Straf. 5; Rep. Crawford, Carr. 4; Rep. Schapiro, Ches. 16; Rep. Cushman, Hills. 2; Rep. Deshaies, Carr. 6; Sen. Sherman, Dist 24; Sen. Bradley, Dist 3; Sen. Rosenwald, Dist 13; Sen. Whitley, Dist 15

COMMITTEE: Children and Family Law

ANALYSIS

This bill requires the department of health and human services to provide medication monitoring for children in foster care and to ensure that the use of medication restraint conforms with the limitations of RSA 126-U.

- -

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

HB 120 - AS AMENDED BY THE HOUSE

7Apr2021... 0517h

21-0052
05/06

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twenty One

AN ACT relative to administration of psychotropic medications to children in foster care.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 New Paragraphs; Delinquent Children; Definitions Added. Amend RSA 169-B:2 by inserting after paragraph XIII the following new paragraphs:

XIII-a "Psychotropic medication" means a drug prescribed by a licensed medical practitioner, to treat illnesses that affect psychological functioning, perception, behavior, or mood.

XIII-b. "Medication restraint" means the involuntary administration of any medication, including psychotropic medication, without a clinical diagnosis for the purpose of controlling behavior, unless it is to ensure the immediate physical safety of persons when there is substantial and imminent risk of serious bodily harm to the child or others.

2 Delinquent Children; Treatment Plan Involving the Use of Psychotropic Medication. Amend RSA 169-B:23 to read as follows:

169-B:23 Orders for [~~Physical~~] ***Health*** Examination and Treatment. If it is alleged in any petition, or it appears at any time during the progress of the case, that a delinquent is in need of [~~physical~~] ***health*** treatment, the failure to receive which is a contributing cause of delinquency, due notice of that fact shall be given as provided in RSA 169-B:7. If the court, upon hearing, finds that such treatment is reasonably required, it shall be ordered and the expense thereof shall be borne as provided in RSA 169-B:40. ***Prior to prescribing psychotropic medication, the prescriber shall ensure the undertaking of, and guidance from, a recent comprehensive medical assessment to rule out an underlying physical cause and a comprehensive psychosocial assessment to address psychosocial issues. The prescribing of any medication shall include consultation with the child's caregiver or legal guardian and the division for children, youth and families (DCYF) district nurse. The use of medication restraint shall be limited as provided in RSA 126-U.***

3 New Paragraphs; Child Protection Act; Definitions Added. Amend RSA 169-C:3 by inserting after paragraph XXV-a the following new paragraphs:

XXV-b. "Psychotropic medication" means a drug prescribed by a licensed medical practitioner, to treat illnesses that affect psychological functioning, perception, behavior, or mood.

XXV-c. "Medication restraint" means the involuntary administration of any medication, including a psychotropic medication, without a clinical diagnosis for the purpose of controlling behavior, unless it is to ensure the immediate physical safety of persons when there is substantial and imminent risk of serious bodily harm to the child or others.

1 4 New Paragraph; Duties of the Department of Health and Human Services Under the Child
2 Protection Act; Oversight of Children in Foster Care Receiving Psychotropic Medication. Amend
3 RSA 169-C:34 by inserting after paragraph VIII the following new paragraph:
4 IX. The use of medication restraint shall be limited as provided in RSA 126-U.
5 5 New Paragraphs; Children in Need of Services (CHINS); Definitions Added. Amend RSA 169-
6 D:2 by inserting after paragraph XIII the following new paragraphs:
7 XIII-a. "Psychotropic medication" means a drug prescribed by a licensed medical
8 practitioner, to treat illnesses that affect psychological functioning, perception, behavior, or mood.
9 XIII-b. "Medication restraint" means the involuntary administration of any medication,
10 including a psychotropic medication, without a clinical diagnosis for the purpose of controlling
11 behavior, unless it is to ensure the immediate physical safety of persons when there is substantial
12 and imminent risk of serious bodily harm to the child or others.
13 6 New Paragraph; Children in Need of Services; Oversight of Children in Foster Care Receiving
14 Psychotropic Medication. Amend RSA 169-D:17 by inserting after paragraph VIII the following new
15 paragraph:
16 IX. The department shall ensure that, when psychotropic medication is prescribed for
17 children in foster care, appropriate medication monitoring is provided pursuant to current American
18 Academy of Child and Adolescent Psychiatry (AACAP) Standards.
19 7 New Subparagraph; Residential Care and Child Placing Agency Licensing; Compliance with
20 Rules Relative to the Use of Psychotropic Medication in Children. Amend RSA 170-E:34, I by
21 inserting after subparagraph (h) the following new subparagraph:
22 (i) Compliance with RSA 126-U, regarding the use of physical and medication restraint.
23 8 New Paragraphs; Services for Children, Youth and Families; Definitions Added. Amend RSA
24 170-G:1 by inserting after paragraph VII the following new paragraphs:
25 VIII. "Psychotropic medication" means a drug prescribed by a licensed medical practitioner,
26 to treat illnesses that affect psychological functioning, perception, behavior, or mood.
27 IX. "Medication restraint" means the involuntary administration of any medication,
28 including a psychotropic medication, without a clinical diagnosis for the purpose of controlling
29 behavior, unless it is to ensure the immediate physical safety of persons when there is substantial
30 and imminent risk of serious bodily harm to the child or others.
31 9 New Paragraph; Duties of the Department of Health and Human Services; Medication
32 Monitoring for Children in Foster Care Receiving Psychotropic Medication. Amend RSA 170-G:4 by
33 inserting after paragraph XXII the following new paragraph:
34 XXIII.(a) Ensure that division for children, youth and families (DCYF) district office nurses
35 provide medication monitoring for children in foster care receiving psychotropic medication pursuant
36 to current American Academy of Child and Adolescent Psychiatry (AACAP) Standards, which shall

1 include providing relevant health education and guidance to caregivers and DCYF field staff, and
2 that any use of medication restraint conforms with the limitations in RSA 126-U.

3 (b) Beginning November 1, 2022, and annually thereafter, report to the joint legislative
4 oversight committee on health and human services established under RSA 126-A:13 and the office of
5 the child advocate established under RSA 21-V, regarding the use of psychotropic medications by
6 children in foster care and compliance with the limitations on medication restraint in RSA 126-U.
7 Such report shall include a description of progress during the preceding fiscal year toward
8 compliance with the recommendations of the September 2018 report of the United States
9 Department of Health and Human Services, Office of the Inspector General entitled "Treatment
10 Planning and Medication Monitoring Were Lacking for Children in Foster Care Receiving
11 Psychotropic Medication." Such description shall include statistical information regarding the
12 number of children in foster care, the number of such children receiving treatment with psychotropic
13 medications, the total Medicaid expenditures for psychotropic medications for such children, and the
14 diagnoses of such children. In addition, the report shall include statistical information regarding the
15 number of children in foster care receiving treatment with psychotropic medications who have
16 treatment plans and medication monitoring as required by statute, regulation, and department
17 procedures.

18 10 New Subparagraph; Confidentiality of Department Case Records; Access by Licensed Medical
19 Practitioner. Amend RSA 170-G:8-a, II(b) by inserting after subparagraph (5) the following new
20 subparagraph:

21 (6) A licensed medical practitioner who is overseeing the use of psychotropic
22 medication prescribed to the child.

23 11 New Paragraph; Foster Care Children's Bill of Rights. Amend RSA 170-G:21 by inserting
24 after paragraph II the following new paragraph:

25 II-a. To receive appropriate medical supervision of any prescribed psychotropic medications.

26 12 Effective Date. This act shall take effect January 1, 2022.

HB 120 - AS AMENDED BY THE SENATE

7Apr2021... 0517h
04/29/2021 1179s

2021 SESSION

21-0052
05/06

HOUSE BILL ***120***

AN ACT relative to administration of psychotropic medications to children in foster care.

SPONSORS: Rep. Marsh, Carr. 8; Rep. P. Schmidt, Straf. 19; Rep. Gay, Rock. 8; Rep. Salloway, Straf. 5; Rep. Crawford, Carr. 4; Rep. Schapiro, Ches. 16; Rep. Cushman, Hills. 2; Rep. Deshaies, Carr. 6; Sen. Sherman, Dist 24; Sen. Bradley, Dist 3; Sen. Rosenwald, Dist 13; Sen. Whitley, Dist 15

COMMITTEE: Children and Family Law

ANALYSIS

This bill requires the department of health and human services to provide medication monitoring for children in foster care and to ensure that the use of medication restraint conforms with the limitations of RSA 126-U.

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Explanation: Matter added to current law appears in ***bold italics.***
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HB 120 - AS AMENDED BY THE SENATE

7Apr2021... 0517h
04/29/2021 1179s

21-0052
05/06

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twenty One

AN ACT relative to administration of psychotropic medications to children in foster care.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 New Paragraphs; Delinquent Children; Definitions Added. Amend RSA 169-B:2 by inserting after paragraph XIII the following new paragraphs:

XIII-a. "Psychotropic medication" means a drug prescribed by a licensed medical practitioner, to treat illnesses that affect psychological functioning, perception, behavior, or mood.

XIII-b. "Medication restraint" means the involuntary administration of any medication, including psychotropic medication, for the purpose of immediate control of behavior.

2 Delinquent Children; Treatment Plan Involving the Use of Psychotropic Medication. Amend RSA 169-B:23 to read as follows:

169-B:23 Orders for [~~Physical~~] ***Health*** Examination and Treatment. If it is alleged in any petition, or it appears at any time during the progress of the case, that a delinquent is in need of [~~physical~~] ***health*** treatment, the failure to receive which is a contributing cause of delinquency, due notice of that fact shall be given as provided in RSA 169-B:7. If the court, upon hearing, finds that such treatment is reasonably required, it shall be ordered and the expense thereof shall be borne as provided in RSA 169-B:40.

3 New Paragraphs; Child Protection Act; Definitions Added. Amend RSA 169-C:3 by inserting after paragraph XXV-a the following new paragraphs:

XXV-b. "Psychotropic medication" means a drug prescribed by a licensed medical practitioner, to treat illnesses that affect psychological functioning, perception, behavior, or mood.

XXV-c. "Medication restraint" means the involuntary administration of any medication, including a psychotropic medication, for the purpose of immediate control of behavior.

4 New Paragraph; Duties of the Department of Health and Human Services Under the Child Protection Act; Oversight of Children in Foster Care Receiving Psychotropic Medication. Amend RSA 169-C:34 by inserting after paragraph VIII the following new paragraph:

IX. The use of medication restraint shall be limited as provided in RSA 126-U.

5 New Paragraphs; Children in Need of Services (CHINS); Definitions Added. Amend RSA 169-D:2 by inserting after paragraph XIII the following new paragraphs:

XIII-a. "Psychotropic medication" means a drug prescribed by a licensed medical practitioner, to treat illnesses that affect psychological functioning, perception, behavior, or mood.

XIII-b. "Medication restraint" means the involuntary administration of any medication, including a psychotropic medication, for the purpose of immediate control of behavior.

1 6 New Paragraph; Children in Need of Services; Oversight of Children in Foster Care Receiving
2 Psychotropic Medication. Amend RSA 169-D:17 by inserting after paragraph VIII the following new
3 paragraph:
4 IX. The department shall ensure that, when psychotropic medication is prescribed for
5 children in foster care, appropriate medication monitoring is provided pursuant to current American
6 Academy of Child and Adolescent Psychiatry (AACAP) Standards.
7 7 New Subparagraph; Residential Care and Child Placing Agency Licensing; Compliance with
8 Rules Relative to the Use of Psychotropic Medication in Children. Amend RSA 170-E:34, I by
9 inserting after subparagraph (h) the following new subparagraph:
10 (i) Compliance with RSA 126-U, regarding the use of physical and medication restraint.
11 8 New Paragraphs; Services for Children, Youth and Families; Definitions Added. Amend RSA
12 170-G:1 by inserting after paragraph VII the following new paragraphs:
13 VIII. "Psychotropic medication" means a drug prescribed by a licensed medical practitioner,
14 to treat illnesses that affect psychological functioning, perception, behavior, or mood.
15 IX. "Medication restraint" means the involuntary administration of any medication,
16 including a psychotropic medication, for the purpose of immediate control of behavior.
17 9 New Paragraph; Duties of the Department of Health and Human Services; Medication
18 Monitoring for Children in Foster Care Receiving Psychotropic Medication. Amend RSA 170-G:4 by
19 inserting after paragraph XXII the following new paragraph:
20 XXIII. Ensure that division for children, youth and families (DCYF) district office nurses
21 provide medication monitoring for children in foster care receiving psychotropic medication pursuant
22 to current American Academy of Child and Adolescent Psychiatry (AACAP) Standards, which shall
23 include providing relevant health education and guidance to caregivers and DCYF field staff, and
24 that any use of medication restraint conforms with the limitations in RSA 126-U.
25 10 New Subparagraph; Confidentiality of Department Case Records; Access by Licensed Medical
26 Practitioner. Amend RSA 170-G:8-a, II(b) by inserting after subparagraph (5) the following new
27 subparagraph:
28 (6) A licensed medical practitioner who is overseeing the use of psychotropic
29 medication prescribed to the child.
30 11 New Paragraph; Foster Care Children's Bill of Rights. Amend RSA 170-G:21 by inserting
31 after paragraph II the following new paragraph:
32 II-a. To receive appropriate medical supervision of any prescribed psychotropic medications.
33 12 New Section; Assessment for the Use of Psychotropic Medications. Amend RSA 170-G by
34 inserting after section 4-g the following new section:
35 170-G:4-h Assessment for the Use of Psychotropic Medications. For children in out-of-home care
36 with the department, prior to seeking a prescription or renewal for psychotropic medication, the
37 department shall ensure the undertaking of, and guidance from, a recent comprehensive medical

1 assessment to rule out an underlying physical cause and a comprehensive psychosocial assessment
2 to address psychosocial issues. The prescribing of any medication shall include consultation with the
3 child's caregiver or legal guardian and the division for children, youth and families (DCYF) district
4 nurse. The use of medication restraint shall be limited as provided in RSA 126-U.
5 13 Effective Date.
6 I. Section 12 of this act shall take effect January 1, 2023.
7 II. The remainder of this act shall take effect January 1, 2022.

CHAPTER 182
HB 120 - FINAL VERSION

7Apr2021... 0517h
04/29/2021 1179s
24Jun2021... 2064EBA

2021 SESSION

21-0052
05/06

HOUSE BILL ***120***

AN ACT relative to administration of psychotropic medications to children in foster care.

SPONSORS: Rep. Marsh, Carr. 8; Rep. P. Schmidt, Straf. 19; Rep. Gay, Rock. 8; Rep. Salloway, Straf. 5; Rep. Crawford, Carr. 4; Rep. Schapiro, Ches. 16; Rep. Cushman, Hills. 2; Rep. Deshaies, Carr. 6; Sen. Sherman, Dist 24; Sen. Bradley, Dist 3; Sen. Rosenwald, Dist 13; Sen. Whitley, Dist 15

COMMITTEE: Children and Family Law

ANALYSIS

This bill requires the department of health and human services to provide medication monitoring for children in foster care and to ensure that the use of medication restraint conforms with the limitations of RSA 126-U.

- -

Explanation: Matter added to current law appears in ***bold italics.***
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Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

CHAPTER 182
HB 120 - FINAL VERSION

7Apr2021... 0517h
04/29/2021 1179s
24Jun2021... 2064EBA

21-0052
05/06

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twenty One

AN ACT relative to administration of psychotropic medications to children in foster care.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 182:1 New Paragraphs; Delinquent Children; Definitions Added. Amend RSA 169-B:2 by
2 inserting after paragraph XIII the following new paragraphs:
3 XIII-a. "Psychotropic medication" means a drug prescribed by a licensed medical
4 practitioner, to treat illnesses that affect psychological functioning, perception, behavior, or mood.
5 XIII-b. "Medication restraint" means the involuntary administration of any medication,
6 including psychotropic medication, for the purpose of immediate control of behavior.
7 182:2 Delinquent Children; Treatment Plan Involving the Use of Psychotropic Medication.
8 Amend RSA 169-B:23 to read as follows:
9 169-B:23 Orders for [~~Physical~~] ***Health*** Examination and Treatment. If it is alleged in any
10 petition, or it appears at any time during the progress of the case, that a delinquent is in need of
11 [~~physical~~] ***health*** treatment, the failure to receive which is a contributing cause of delinquency, due
12 notice of that fact shall be given as provided in RSA 169-B:7. If the court, upon hearing, finds that
13 such treatment is reasonably required, it shall be ordered and the expense thereof shall be borne as
14 provided in RSA 169-B:40.
15 182:3 New Paragraphs; Child Protection Act; Definitions Added. Amend RSA 169-C:3 by
16 inserting after paragraph XXV-a the following new paragraphs:
17 XXV-b. "Psychotropic medication" means a drug prescribed by a licensed medical
18 practitioner, to treat illnesses that affect psychological functioning, perception, behavior, or mood.
19 XXV-c. "Medication restraint" means the involuntary administration of any medication,
20 including a psychotropic medication, for the purpose of immediate control of behavior.
21 182:4 New Paragraph; Duties of the Department of Health and Human Services Under the
22 Child Protection Act; Oversight of Children in Foster Care Receiving Psychotropic Medication.
23 Amend RSA 169-C:34 by inserting after paragraph VIII the following new paragraph:
24 IX. The use of medication restraint shall be limited as provided in RSA 126-U.
25 182:5 New Paragraphs; Children in Need of Services (CHINS); Definitions Added. Amend RSA
26 169-D:2 by inserting after paragraph XIII the following new paragraphs:
27 XIII-a. "Psychotropic medication" means a drug prescribed by a licensed medical
28 practitioner, to treat illnesses that affect psychological functioning, perception, behavior, or mood.

1 XIII-b. "Medication restraint" means the involuntary administration of any medication,
2 including a psychotropic medication, for the purpose of immediate control of behavior.
3 182:6 New Paragraph; Children in Need of Services; Oversight of Children in Foster Care
4 Receiving Psychotropic Medication. Amend RSA 169-D:17 by inserting after paragraph VIII the
5 following new paragraph:
6 IX. The department shall ensure that, when psychotropic medication is prescribed for
7 children in foster care, appropriate medication monitoring is provided pursuant to current American
8 Academy of Child and Adolescent Psychiatry (AACAP) Standards.
9 182:7 New Subparagraph; Residential Care and Child Placing Agency Licensing; Compliance
10 with Rules Relative to the Use of Psychotropic Medication in Children. Amend RSA 170-E:34, I by
11 inserting after subparagraph (h) the following new subparagraph:
12 (i) Compliance with RSA 126-U, regarding the use of physical and medication restraint.
13 182:8 New Paragraphs; Services for Children, Youth and Families; Definitions Added. Amend
14 RSA 170-G:1 by inserting after paragraph VII the following new paragraphs:
15 VIII. "Psychotropic medication" means a drug prescribed by a licensed medical practitioner,
16 to treat illnesses that affect psychological functioning, perception, behavior, or mood.
17 IX. "Medication restraint" means the involuntary administration of any medication,
18 including a psychotropic medication, for the purpose of immediate control of behavior.
19 182:9 New Paragraph; Duties of the Department of Health and Human Services; Medication
20 Monitoring for Children in Foster Care Receiving Psychotropic Medication. Amend RSA 170-G:4 by
21 inserting after paragraph XXII the following new paragraph:
22 XXIII. Ensure that division for children, youth and families (DCYF) district office nurses
23 provide medication monitoring for children in foster care receiving psychotropic medication pursuant
24 to current American Academy of Child and Adolescent Psychiatry (AACAP) Standards, which shall
25 include providing relevant health education and guidance to caregivers and DCYF field staff, and
26 that any use of medication restraint conforms with the limitations in RSA 126-U.
27 182:10 New Subparagraph; Confidentiality of Department Case Records; Access by Licensed
28 Medical Practitioner. Amend RSA 170-G:8-a, II(b) by inserting after subparagraph (5) the following
29 new subparagraph:
30 (6) A licensed medical practitioner who is overseeing the use of psychotropic
31 medication prescribed to the child.
32 182:11 New Paragraph; Foster Care Children's Bill of Rights. Amend RSA 170-G:21 by
33 inserting after paragraph II the following new paragraph:
34 II-a. To receive appropriate medical supervision of any prescribed psychotropic medications.
35 182:12 New Section; Assessment for the Use of Psychotropic Medications. Amend RSA 170-G by
36 inserting after section 4-h the following new section:

1 170-G:4-i Assessment for the Use of Psychotropic Medications. For children in out-of-home care
2 with the department, prior to seeking a prescription or renewal for psychotropic medication, the
3 department shall ensure the undertaking of, and guidance from, a recent comprehensive medical
4 assessment to rule out an underlying physical cause and a comprehensive psychosocial assessment
5 to address psychosocial issues. The prescribing of any medication shall include consultation with the
6 child's caregiver or legal guardian and the division for children, youth and families (DCYF) district
7 nurse. The use of medication restraint shall be limited as provided in RSA 126-U.
8 182:13 Effective Date.
9 I. Section 12 of this act shall take effect January 1, 2023.
II. The remainder of this act shall take effect January 1, 2022.

Approved: August 10, 2021
Effective Date:
I. Section 12 shall take effect January 1, 2023.
II. Remainder shall take effect January 1, 2022.

Amendments

Sen. Bradley, Dist 3
April 20, 2021
2021-1166s
05/06

Amendment to HB 120

Amend the bill by replacing all after the enacting clause with the following:

1 New Paragraphs; Delinquent Children; Definitions Added. Amend RSA 169-B:2 by inserting after paragraph XIII the following new paragraphs:

XIII-a. "Psychotropic medication" means a drug prescribed by a licensed medical practitioner, to treat illnesses that affect psychological functioning, perception, behavior, or mood.

XIII-b. "Medication restraint" means the involuntary administration of any medication, including psychotropic medication, without a clinical diagnosis for the purpose of immediate control of behavior.

2 Delinquent Children; Treatment Plan Involving the Use of Psychotropic Medication. Amend RSA 169-B:23 to read as follows:

169-B:23 Orders for [~~Physical~~] ***Health*** Examination and Treatment. If it is alleged in any petition, or it appears at any time during the progress of the case, that a delinquent is in need of [~~physical~~] ***health*** treatment, the failure to receive which is a contributing cause of delinquency, due notice of that fact shall be given as provided in RSA 169-B:7. If the court, upon hearing, finds that such treatment is reasonably required, it shall be ordered and the expense thereof shall be borne as provided in RSA 169-B:40.

3 New Paragraphs; Child Protection Act; Definitions Added. Amend RSA 169-C:3 by inserting after paragraph XXV-a the following new paragraphs:

XXV-b. "Psychotropic medication" means a drug prescribed by a licensed medical practitioner, to treat illnesses that affect psychological functioning, perception, behavior, or mood.

XXV-c. "Medication restraint" means the involuntary administration of any medication, including a psychotropic medication, without a clinical diagnosis for the purpose of immediate control of behavior.

4 New Paragraph; Duties of the Department of Health and Human Services Under the Child Protection Act; Oversight of Children in Foster Care Receiving Psychotropic Medication. Amend RSA 169-C:34 by inserting after paragraph VIII the following new paragraph:

IX. The use of medication restraint shall be limited as provided in RSA 126-U.

5 New Paragraphs; Children in Need of Services (CHINS); Definitions Added. Amend RSA 169-D:2 by inserting after paragraph XIII the following new paragraphs:

XIII-a. "Psychotropic medication" means a drug prescribed by a licensed medical practitioner, to treat illnesses that affect psychological functioning, perception, behavior, or mood.

1 XIII-b. "Medication restraint" means the involuntary administration of any medication,
2 including a psychotropic medication, without a clinical diagnosis for the purpose of immediate
3 control of behavior.
4 6 New Paragraph; Children in Need of Services; Oversight of Children in Foster Care Receiving
5 Psychotropic Medication. Amend RSA 169-D:17 by inserting after paragraph VIII the following new
6 paragraph:
7 IX. The department shall ensure that, when psychotropic medication is prescribed for
8 children in foster care, appropriate medication monitoring is provided pursuant to current American
9 Academy of Child and Adolescent Psychiatry (AACAP) Standards.
10 7 New Subparagraph; Residential Care and Child Placing Agency Licensing; Compliance with
11 Rules Relative to the Use of Psychotropic Medication in Children. Amend RSA 170-E:34, I by
12 inserting after subparagraph (h) the following new subparagraph:
13 (i) Compliance with RSA 126-U, regarding the use of physical and medication restraint.
14 8 New Paragraphs; Services for Children, Youth and Families; Definitions Added. Amend RSA
15 170-G:1 by inserting after paragraph VII the following new paragraphs:
16 VIII. "Psychotropic medication" means a drug prescribed by a licensed medical practitioner,
17 to treat illnesses that affect psychological functioning, perception, behavior, or mood.
18 IX. "Medication restraint" means the involuntary administration of any medication,
19 including a psychotropic medication, without a clinical diagnosis for the purpose of immediate
20 control of behavior.
21 9 New Paragraph; Duties of the Department of Health and Human Services; Medication
22 Monitoring for Children in Foster Care Receiving Psychotropic Medication. Amend RSA 170-G:4 by
23 inserting after paragraph XXII the following new paragraph:
24 XXIII. Ensure that division for children, youth and families (DCYF) district office nurses
25 provide medication monitoring for children in foster care receiving psychotropic medication pursuant
26 to current American Academy of Child and Adolescent Psychiatry (AACAP) Standards, which shall
27 include providing relevant health education and guidance to caregivers and DCYF field staff, and
28 that any use of medication restraint conforms with the limitations in RSA 126-U.
29 10 New Subparagraph; Confidentiality of Department Case Records; Access by Licensed Medical
30 Practitioner. Amend RSA 170-G:8-a, II(b) by inserting after subparagraph (5) the following new
31 subparagraph:
32 (6) A licensed medical practitioner who is overseeing the use of psychotropic
33 medication prescribed to the child.
34 11 New Paragraph; Foster Care Children's Bill of Rights. Amend RSA 170-G:21 by inserting
35 after paragraph II the following new paragraph:
36 II-a. To receive appropriate medical supervision of any prescribed psychotropic medications.
37

APPROVED

1 12 New Section; Assessment for the Use of Psychotropic Medications. Amend RSA 170-G by
2 inserting after section 4-g the following new section:
3 170-G:4-h Assessment for the Use of Psychotropic Medications. For children in out-of-home care
4 with the department, prior to seeking a prescription or renewal for psychotropic medication, the
5 department shall ensure the undertaking of, and guidance from, a recent comprehensive medical
6 assessment to rule out an underlying physical cause and a comprehensive psychosocial assessment
7 to address psychosocial issues. The prescribing of any medication shall include consultation with the
8 child's caregiver or legal guardian and the division for children, youth and families (DCYF) district
9 nurse. The use of medication restraint shall be limited as provided in RSA 126-U.
10 13 Effective Date.
11 I. Section 12 of this act shall take effect January 1, 2023.
12 II. The remainder of this act shall take effect January 1, 2022.

UNAPPROVED

Health and Human Services
April 21, 2021
2021-1179s
05/06

Amendment to HB 120

Amend the bill by replacing all after the enacting clause with the following:

1 New Paragraphs; Delinquent Children; Definitions Added. Amend RSA 169-B:2 by inserting after paragraph XIII the following new paragraphs:

XIII-a. "Psychotropic medication" means a drug prescribed by a licensed medical practitioner, to treat illnesses that affect psychological functioning, perception, behavior, or mood.

XIII-b. "Medication restraint" means the involuntary administration of any medication, including psychotropic medication, for the purpose of immediate control of behavior.

2 Delinquent Children; Treatment Plan Involving the Use of Psychotropic Medication. Amend RSA 169-B:23 to read as follows:

169-B:23 Orders for [~~Physical~~] ***Health*** Examination and Treatment. If it is alleged in any petition, or it appears at any time during the progress of the case, that a delinquent is in need of [~~physical~~] ***health*** treatment, the failure to receive which is a contributing cause of delinquency, due notice of that fact shall be given as provided in RSA 169-B:7. If the court, upon hearing, finds that such treatment is reasonably required, it shall be ordered and the expense thereof shall be borne as provided in RSA 169-B:40.

3 New Paragraphs; Child Protection Act; Definitions Added. Amend RSA 169-C:3 by inserting after paragraph XXV-a the following new paragraphs:

XXV-b. "Psychotropic medication" means a drug prescribed by a licensed medical practitioner, to treat illnesses that affect psychological functioning, perception, behavior, or mood.

XXV-c. "Medication restraint" means the involuntary administration of any medication, including a psychotropic medication, for the purpose of immediate control of behavior.

4 New Paragraph; Duties of the Department of Health and Human Services Under the Child Protection Act; Oversight of Children in Foster Care Receiving Psychotropic Medication. Amend RSA 169-C:34 by inserting after paragraph VIII the following new paragraph:

IX. The use of medication restraint shall be limited as provided in RSA 126-U.

5 New Paragraphs; Children in Need of Services (CHINS); Definitions Added. Amend RSA 169-D:2 by inserting after paragraph XIII the following new paragraphs:

XIII-a. "Psychotropic medication" means a drug prescribed by a licensed medical practitioner, to treat illnesses that affect psychological functioning, perception, behavior, or mood.

XIII-b. "Medication restraint" means the involuntary administration of any medication, including a psychotropic medication, for the purpose of immediate control of behavior.

1 6 New Paragraph; Children in Need of Services; Oversight of Children in Foster Care Receiving
2 Psychotropic Medication. Amend RSA 169-D:17 by inserting after paragraph VIII the following new
3 paragraph:
4 IX. The department shall ensure that, when psychotropic medication is prescribed for
5 children in foster care, appropriate medication monitoring is provided pursuant to current American
6 Academy of Child and Adolescent Psychiatry (AACAP) Standards.
7 7 New Subparagraph; Residential Care and Child Placing Agency Licensing; Compliance with
8 Rules Relative to the Use of Psychotropic Medication in Children. Amend RSA 170-E:34, I by
9 inserting after subparagraph (h) the following new subparagraph:
10 (i) Compliance with RSA 126-U, regarding the use of physical and medication restraint.
11 8 New Paragraphs; Services for Children, Youth and Families; Definitions Added. Amend RSA
12 170-G:1 by inserting after paragraph VII the following new paragraphs:
13 VIII. "Psychotropic medication" means a drug prescribed by a licensed medical practitioner,
14 to treat illnesses that affect psychological functioning, perception, behavior, or mood.
15 IX. "Medication restraint" means the involuntary administration of any medication,
16 including a psychotropic medication, for the purpose of immediate control of behavior.
17 9 New Paragraph; Duties of the Department of Health and Human Services; Medication
18 Monitoring for Children in Foster Care Receiving Psychotropic Medication. Amend RSA 170-G:4 by
19 inserting after paragraph XXII the following new paragraph:
20 XXIII. Ensure that division for children, youth and families (DCYF) district office nurses
21 provide medication monitoring for children in foster care receiving psychotropic medication pursuant
22 to current American Academy of Child and Adolescent Psychiatry (AACAP) Standards, which shall
23 include providing relevant health education and guidance to caregivers and DCYF field staff, and
24 that any use of medication restraint conforms with the limitations in RSA 126-U.
25 10 New Subparagraph; Confidentiality of Department Case Records; Access by Licensed Medical
26 Practitioner. Amend RSA 170-G:8-a, II(b) by inserting after subparagraph (5) the following new
27 subparagraph:
28 (6) A licensed medical practitioner who is overseeing the use of psychotropic
29 medication prescribed to the child.
30 11 New Paragraph; Foster Care Children's Bill of Rights. Amend RSA 170-G:21 by inserting
31 after paragraph II the following new paragraph:
32 II-a. To receive appropriate medical supervision of any prescribed psychotropic medications.
33 12 New Section; Assessment for the Use of Psychotropic Medications. Amend RSA 170-G by
34 inserting after section 4-g the following new section:
35 170-G:4-h Assessment for the Use of Psychotropic Medications. For children in out-of-home care
36 with the department, prior to seeking a prescription or renewal for psychotropic medication, the
37 department shall ensure the undertaking of, and guidance from, a recent comprehensive medical

1 assessment to rule out an underlying physical cause and a comprehensive psychosocial assessment
2 to address psychosocial issues. The prescribing of any medication shall include consultation with the
3 child's caregiver or legal guardian and the division for children, youth and families (DCYF) district
4 nurse. The use of medication restraint shall be limited as provided in RSA 126-U.
5 13 Effective Date.
6 I. Section 12 of this act shall take effect January 1, 2023.
7 II. The remainder of this act shall take effect January 1, 2022.

Committee Minutes

SENATE CALENDAR NOTICE
Health and Human Services

Sen Jeb Bradley, Chair
Sen James Gray, Vice Chair
Sen Kevin Avard, Member
Sen Tom Sherman, Member
Sen Rebecca Whitley, Member

Date: April 8, 2021

HEARINGS

Wednesday	04/14/2021
(Day)	(Date)

Health and Human Services	REMOTE 000	9:00 a.m.
(Name of Committee)	(Place)	(Time)

9:00 a.m.	**HB 600-FN**	relative to funding for newborn screening.
9:15 a.m.	**HB 582**	relative to prescriptions for the treatment of attention deficit disorder, attention deficit disorder with hyperactivity, or narcolepsy.
9:30 a.m.	**HB 120**	relative to administration of psychotropic medications to children in foster care.
9:45 a.m.	**HB 220**	establishing medical freedom in immunizations.

Committee members will receive secure Zoom invitations via email.

Members of the public may attend using the following links:

1. Link to Zoom Webinar: https://www.zoom.us/j/98999311863
2. To listen via telephone: Dial(for higher quality, dial a number based on your current location): 1-301-715-8592, or 1-312-626-6799 or 1-929-205-6099, or 1-253-215-8782, or 1-346-248-7799, or 1-669-900-6833
3. Or iPhone one-tap: 13017158592,,98999311863# or 13126266799,,98999311863#
4. Webinar ID: 989 9931 1863
5. To view/listen to this hearing on YouTube, use this link: https://www.youtube.com/channel/UCjBZdtrjRnQdmg-2MPMiWrA

6. To sign in to speak, register your position on a bill and/or submit testimony, use this link: http://gencourt.state.nh.us/remotecommittee/senate.aspx

The following email will be monitored throughout the meeting by someone who can assist with and alert the committee to any technical issues: remotesenate@leg.state.nh.us or call (603-271-6931).

EXECUTIVE SESSION MAY FOLLOW

Sponsors:

HB 600-FN

Rep. Marsh	Rep. Salloway	Rep. Woods	Rep. Nelson
Sen. Bradley			

HB 582

Rep. Walz	Rep. Woods

HB 120

Rep. Marsh	Rep. P. Schmidt	Rep. Gay	Rep. Salloway
Rep. Crawford	Rep. Schapiro	Rep. Cushman	Rep. Deshaies
Sen. Sherman	Sen. Bradley	Sen. Rosenwald	Sen. Whitley

HB 220

Rep. Lang	Rep. Nunez	Rep. Rouillard	Rep. Pearl
Rep. Binford	Rep. Harvey-Bolia	Rep. Rice	Rep. Notter
Rep. Bordes	Rep. Pauer	Sen. Avard	

Kirsten Koch 271-3266

Jeb Bradley
Chairman

Senate Health and Human Services Committee

Kirsten Koch 271-3266

HB 120, relative to administration of psychotropic medications to children in foster care.

Hearing Date: April 14, 2021

Time Opened: 10:09 a.m. **Time Closed:** 10:21 a.m.

Members of the Committee Present: Senators Bradley, Gray, Avard, Sherman and Whitley

Members of the Committee Absent : None

Bill Analysis: This bill requires the department of health and human services to provide medication monitoring for children in foster care and to ensure that the use of medication restraint conforms with the limitations of RSA 126-U.

Sponsors:

Rep. Marsh	Rep. P. Schmidt	Rep. Gay
Rep. Salloway	Rep. Crawford	Rep. Schapiro
Rep. Cushman	Rep. Deshaies	Sen. Sherman
Sen. Bradley	Sen. Rosenwald	Sen. Whitley

Who supports the bill: There are 49 names signed in support of this bill. To view the sign in sheet, please contact the Legislative Aide for the Senate Health and Human Services Committee, Kirsten Koch, at kirsten.koch@leg.state.nh.us

Who opposes the bill: None

Who is neutral on the bill: None

Summary of Testimony Presented:

Representative William Marsh, Carroll 8

- Rep. Marsh introduced the bill and thanked Sen. Whitley for drafting the original version of the bill.
- Rep. Marsh said he filed this bill in response to the US Inspector General 2018 report, which reviewed Medicaid claim data of the five states with the highest instances of children in foster care taking psychotropic medications.
- Rep. Marsh said, if a state is not in conformity with the plan, the feds can withhold funding. There are treatment plans for 61% of children with no diagnosis in foster care in NH. Further, 28% children did not receive medical monitoring. Medical restraint can be used so long as medical practitioners monitor it.
- Rep. Marsh said, the state of California has successfully reduced the use of anti-psychotic medications for foster kids.

- Rep. Marsh said, in 2016, NH spent $1 million on psychotropic medications for foster care kids. I estimate this bill will save $783,000 in the NH Medicare budget.

Moira O'Neill, NH Child Advocate

- Ms. O'Neill testified in support of this bill.
- Ms. O'Neill said, foster children do not have the consistency of one parent to manage their medication.
- Ms. O'Neill said, we worked with the New Hampshire Psychiatric Society on several suggested amendments to the original bill. The amendments were not complete, however, in that the standard of care, which calls for a full medical assessment and psychosocial assessment, was only inserted in RSA 169-B:23 governing care of children adjudicated delinquent. In order to ensure proper use of psychotropic medications with children in foster care, the same paragraph should be inserted in the proposed new paragraph in RSA 169-C:34 governing the duties of the department. On the bill as amended, that would be Page 2, after Line 4. We would recommend inserting the paragraph proposed on Page 1, lines 16-22: Prior to prescribing psychotropic medication, the prescriber shall ensure the undertaking of, and guidance from, a recent comprehensive medical assessment to rule out an underlying physical cause and a comprehensive psychosocial assessment to address psychosocial issues. The prescribing of any medication shall include consultation with the child's caregiver or legal guardian and the division for children, youth and families (DCYF) district nurse. The use of medication restraint shall be limited as provided in RSA 126-U.
- Ms. O'Neill said, the standard of care is a full medical assessment. My proposal to enhance capacity for prescribers in NH because of the shortage of psychiatry providers. We could provide resources to allow primary care physicians to prescribe psychotropic medications with guidance from psychiatric providers. This would be a resource for all children in need. Some of the children ending up in emergency rooms is because they need medication adjustments.
- Ms. O'Neill said, we support the bill with these adjustments.

Ms. O'Neill accidentally provided her testimony on HB 120 during the hearing for HB 582. Sen. Bradley recommended for Ms. O'Neill to take any questions during the hearing for HB 120. Below are the questions for Ms. O'Neil during the hearing on HB 120:

- Sen. Whitley asked, you mentioned a potential amendment related to the requirement of an assessment for the standard or care. Can you forward your proposed language?
  - Ms. O'Neill said, yes, it is actually in my written testimony.
- Sen. Whitley, that would make it consistent with reforms done with child protection and child behavioral health system? Would that match with an assessment?
  - Ms. O'Neill said, yes. It was added under a delinquency statute. We are finding there are a number of children in the state that have underlying medical conditions and they are receiving psychotropic medications. It is always best to do a full medical work up before prescribing psychotropic medications. This is a prompt for the standard of care—a full medical review before prescribing the medications.

Michael Skibbie, Disability Rights Center NH

- Mr. Skibbie said he wanted to address the problem with the definition of medical restraint in the bill, specifically where it says, "unless when the use of medication of use to restrain would be permitted."
- Mr. Skibbie said, restraint medication is overseen by the Attorney General, DHHS, Department of Education, and the Disability Rights Center. Incorporating the legal justification of medication restraints would relieve providers the need to notify all oversight. All medication restraint is regulated, and prescribers must notify oversight even when justifications have been met. This definition would allow a provider to conclude "because we think this was justified" not to keep records, or tell the parent, and not to create a problem with the current statutory scheme.

Sen. Bradley said, Mr. Skibbie and Ms. O'Neill should work with Rep. Marsh to clarify the bill, delete lines, and work on any other amendments to bring back to the committee.

KNK
Date Hearing Report completed: April 16, 2021

Speakers

Senate Remote Testify

Health and Human Services Committee Testify List for Bill HB120 on 2021-04-

Support: 45 Oppose: 0 Neutral: 0 Total to Testify: 1

Name	Email Address	Phone	Title	Representing	Position	Testifing
Marsh, William	wmarshmd@gmail.com	603.569.6382	An Elected Official	Carroll 8	Support	Yes
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McKeown, Susan	swmckeown48@yahoo.com	603.668.4859	A Member of the Public	Myself	Support	No
Bates, David	dbates3@yahoo.com	603.748.2668	A Member of the Public	Myself	Support	No
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Lucas, Janet	janluca1953@gmail.com	16037267614	A Member of the Public	Myself	Support	No
Fenner-Lukaitis, Elizabeth	glukaitis@mcttelecom.com	Not Given	A Member of the Public	Myself	Support	No
Sherman, Senator Tom	jennifer.horgan@leg.state.nh.us	271-7875	An Elected Official	SD24	Support	No
Quinney, Glenn	Not Given	Not Given	A Member of the Public	Myself	Support	No
Padmore, Michael	michael.padmore@nhms.org	603.858.4744	A Lobbyist	NH Medical Society	Support	No
Ho, Dr. Patrick	Not Given	Not Given	A Member of the Public	NH Psychiatric Society	Support	No
Reed, Barbara D.	BDReed74@gmail.com	Not Given	A Member of the Public	Myself	Support	No
Hansen, Sarah	Not Given	Not Given	A Member of the Public	Myself	Support	No
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Clark, Denise	denise.m.clark03055@gmail.com	603.213.1692	A Member of the Public	Myself	Support	No
Douville, Linda	Not Given	Not Given	A Member of the Public	Myself	Support	No
Spielman, Kathy	jspielman@comcast.net	603.397.7879	A Member of the Public	Myself	Support	No
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Laker-Phelps, Gail	lpsart@tds.net	603.798.5394	A Member of the Public	Myself	Support	No
Platt, Elizabeth-Anne	lizanneplatt09@gmail.com	Not Given	A Member of the Public	Myself	Support	No
Ellermann, Maureen	Not Given	Not Given	A Member of the Public	Myself	Support	No
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Avery, Cheryl	cavery@new-futures.org	603-217-7982	A Lobbyist	New Futures - Children's Behavioral Health	Support	No
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Hinebauch, Mel	Not Given	603.224.4866	A Member of the Public	Myself	Support	No
Brunelle, Leigh	Not Given	603.674.9263	A Member of the Public	Myself	Support	No
Roy, Leo B	Not Given	603.486.5060	A Member of the Public	Myself	Support	No
Falk, Cheri	Falk.cj@gmail.com	603.801.4651	A Member of the Public	Myself	Support	No
Damon, Claudia	cordsdamon@gmail.com	603.226.4561	A Member of the Public	Myself	Support	No
Perencevich, Ruth	Not Given	Not Given	A Member of the Public	Myself	Support	No
Richman, Susan	susan7richman@gmail.com	603.868.2758	A Member of the Public	Myself	Support	No
Torpey, Jeanne	Not Given	Not Given	A Member of the Public	Myself	Support	No
Bradley, Jeb	jeb.bradley@leg.state.nh.us	603.271.4151	An Elected Official	SD3	Support	No

Testimony

April 14, 2021

The Honorable Jeb Bradley, Chair
NH Senate Health and Human Services Committee
Legislative Office Building
33 North State Street
Concord, NH 03301

Re: New Futures' Support for HB s120 re: to Psychotropic medications for children in foster care

Dear Chairman Bradley and Honorable Members of the Committee,

My name is Cheryl Avery and I am the Policy Coordinator for Children's Behavioral Health at New Futures. New Futures appreciates the opportunity to testify in support of HB 120 with today's Amendment 0517H, relative to psychotropic medications for children in foster care.

New Futures is a nonpartisan, nonprofit organization that advocates, educates, and collaborates to improve the health and wellness of all New Hampshire residents. We work extensively with policy makers, care providers, and families to address behavioral health issues facing our state.

I am writing today in strong support of House Bill 120. This important legislation will go a long way in the effort to limit and reduce the use of psychotropic medications for children in New Hampshire's care. Similar legislation in other states has shown a dramatic decrease in the use of psychotropic medications.

By tightening oversight and ensuring that every child who is prescribed medication has a proper diagnosis and a corresponding treatment plan, we can be more confident that every child in New Hampshire's state care is receiving the appropriate treatment.

For the well- being of New Hampshire's children, we respectfully request that the Committee recommend HB120 Ought to Pass.

Thank you for your time and your consideration of this very important matter. Please do not hesitate to contact me if you have any questions.

Respectfully submitted,

Cheryl L. Avery, Policy Coordinator
Children's Behavioral Health, New Futures
cavery@new-futures.org
603/217-7982

State of New Hampshire

Office of the Child Advocate

Moira O'Neill
Child Advocate

Testimony of
Moira O'Neill, PhD
The Child Advocate
before
The New Hampshire Senate Health and Human Services Committee
April 14, 2021

Good morning Chairman Bradley, Vice Chair Gray and members of the Committee. My name is Moira O'Neill and I am the State Child Advocate. The Office of the Child Advocate is an independent state oversight agency. Recently the Office's jurisdiction expanded by RSA 21-V, to all children's services provided or arranged for by the State. However, a focus of our work will always be children involved with or at risk of needing child protection and being placed in foster care. Thank you for the opportunity to speak to you today in support of **House Bill 120, relative to administration of psychotropic medications to children in foster care.**

The Office of the Child Advocate supports HB 120. We worked with the New Hampshire Psychiatric Society on several suggested amendments to the original bill. The amendments were not complete, however, in that the standard of care, which calls for a full medical assessment and psychosocial assessment, was only inserted in RSA 169-B:23 governing care of children adjudicated delinquent. In order to ensure proper use of psychotropic medications with children in foster care, the same paragraph should be inserted in the proposed new paragraph in RSA 169-C:34 governing the duties of the department. On the bill as amended, that would be Page 2, after Line 4. We would recommend inserting the paragraph proposed on Page 1, lines 16-22: ***Prior to prescribing psychotropic medication, the prescriber shall ensure the undertaking of, and guidance from, a recent comprehensive medical assessment to rule out an underlying physical cause and a comprehensive psychosocial assessment to address psychosocial issues. The prescribing of any medication shall include consultation with the child's caregiver or legal guardian and the division for children, youth and families (DCYF) district nurse. The use of medication restraint shall be limited as provided in RSA 126-U.***

Ensuring monitoring of psychotropic medications for children in foster care is an urgent matter. The 2018 U.S. Office of Inspector General's report entitled "Treatment Planning and Medication Monitoring Were Lacking for Children in Foster Care Receiving Psychotropic Medication" (Inspector General's Report) found that twenty-two percent of children in foster care in New Hampshire "did not receive medication monitoring by a prescribing professional."[1] The report further pointed out that New Hampshire was one of five states with the highest percentages of "children in foster care who were treated with psychotropic medications in FY 2013, the most recent year for which there was complete data available in the Medicaid Statistical Information System."[2]

Children in DCYF custody are predominantly children who are victims of abuse, neglect, or other family dysfunction causing high rate of adverse childhood experiences (ACES). ACEs are associated with mental illness and communication disorders that manifest as problem behavior.[3] Generally, removal from home

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[1] Available at https://oig.hhs.gov/oei/reports/oei-07-15-00380.pdf.

[2] Available at https://oig.hhs.gov/oei/reports/oei-07-15-00380.pdf.

[3] Felitti, VJ, Anda, RF, Nordenberg, D Edwards, V, Koss, MP, Marks, JS (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE)

is a response to the need for safety. Treatment is prompted by persistent symptoms of mental illness or the problem behavior. The Inspector General's report, and others before it,[4] indicate that the response to these distressed children has been to medicate them with psychotropic drugs. Anecdotally, the Office of the Child Advocate has reviewed children's cases in which problematic changes in a child's behavior appear primarily addressed with medication changes. In some of those cases, we have seen it later discovered that the manifested behaviors were in fact caused by underlying physical conditions.

For these reasons, the Office of the Child Advocate urges the Committee to pass **HB 120, relative to administration of psychotropic medications to children in foster care.**

Thank you very much for taking my testimony. I welcome any questions you may have.

Post script:

The effects of psychotropic medications in children are not entirely understood, and because of the nature of their developing brains, there have been few clinical trials of the drugs on children. I provide a simple table of known side effects to demonstrate the importance of monitoring. There are three categories of side effects with the various types of psychotropic drugs including stimulants, antipsychotics and mood stabilizers.[5]

Minor	Headaches, drowsiness, thirst and increased urination, dry or metallic taste in mouth
Moderate	Decreased appetite, restlessness, nausea, vomiting, diarrhea, trembling, acne, hair loss, dizziness, irritability, blood sugar fluctuations
Severe	Obesity, hypertension, seizures, bed wetting, abnormal kidney, liver, thyroid, and parathyroid function, increased white blood cells, cardiac arrhythmias, suicidality

Necessary monitoring of the use of psychotropic drugs includes evidence basis for prescribing, observation of intended and unintended effects, periodic blood tests for drug levels, impact on organ function, and interactions with other medications and foods. Most importantly, monitoring should also include access to non-pharmacological interventions.

study. *American Journal of Preventive Medicine*, 14 (4): P245-258. DOI: https://doi.org/10.1016/S0749-3797(98)00017-8.

[4] Stambaugh, L.F., Leslie, L.K., Ringeisen, H., Smith, K., & Hodgkin, D. **(2012).** *Psychotropic medication use by children in child welfare*. OPRE Report #2012-33, Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

[5] American Academy of Child & Adolescent Psychiatry (2012). A Guide for Community Child Serving Agencies on Psychotropic Medications for Children and Adolescents. http://www.aacap.org/App_Themes/AACAP/docs/press/guide_for_community_child_serving_agencies_on_psychotropic_medications_for_children_and_adolescents_2012.pdf

Good morning! For the record I am Rep. Marsh, Carroll 8, representing 7 towns in southern Carroll County.

I am pleased to bring you today HB120, relative to the use of psychotropic medications for children in foster care. Senator Whitley is familiar with this bill, as she collaborated in drafting the original version several years ago.

This bill was filed in response to the United States Inspector General's Sept 2018 report "Treatment Planning and Medication Monitoring were Lacking for Children in Foster Care Receiving Psychotropic Medication" which I have also emailed to the committee for the permanent record. Note especially p. 23 which summarizes specifics relevant to NH, and which I emailed you separately for convenience.

What the Office of the Inspector General did is review Medicaid claims data and clinical records in the 5 states which reported the highest percentages of children in foster care receiving psychotropic medications – NH is #3. It did this because the Administration for Children and Families (ACF) is responsible for awarding Federal funding to State's child welfare programs and for overseeing those programs. And it reminded us, on page 3 of its report, that if ACF finds that a State is not in substantial conformity with its state plan, it has the authority to withhold a certain amount of Federal funding.

What the Inspector General found, is that 23.4% of NH children in foster care receiving psychotropic medications had no treatment plan. 37.9% had a treatment plan but no diagnosis on their treatment plan. As a doctor, I am most troubled that the total of these numbers is 61.3% – meaning the majority of these kids in NH had no diagnosis. And 21.8% of these children did not receive medication monitoring by a prescribing professional.

HB120 is actually a pretty simple bill. It defines "medication restraint" as the use of psychotropic drugs without a clinical diagnosis and applies the existing law in RSA 126-U to such use. Medication restrain is specifically referenced in RSA 126-U:1 IV. So long as medical practitioners are treating disease – or in other words list a diagnosis – this will never apply to legitimate medical treatment. This is similar to how we limited the use of psychotropic medications as a restraint in hospitals and nursing homes a generation ago.

California passed a similar bill tightening oversight over the use of psychotropic medications in foster care in 2015, and it has resulted in a 45% reduction in antipsychotic prescriptions to foster care kids, and a 73% reduction in prescriptions for multiple psychotropic drugs. The Inspector General on p. 31 of his report said that NH spent $1,741,581 for psychotropic medications for foster care kids in 2016. While this bill lacks a fiscal note, I would contend that a similar 45% reduction in NH would result in a $783,711 savings in the NH budget.

Thank you, and I will be glad to answer questions.

U.S. Department of Health and Human Services

Office of Inspector General

Treatment Planning and Medication Monitoring Were Lacking for Children in Foster Care Receiving Psychotropic Medication

OEI-07-15-00380

September 2018

Daniel R. Levinson
Inspector General

Report in Brief
September 2018
OEI-07-15-00380

U.S. Department of Health and Human Services

Office of Inspector General

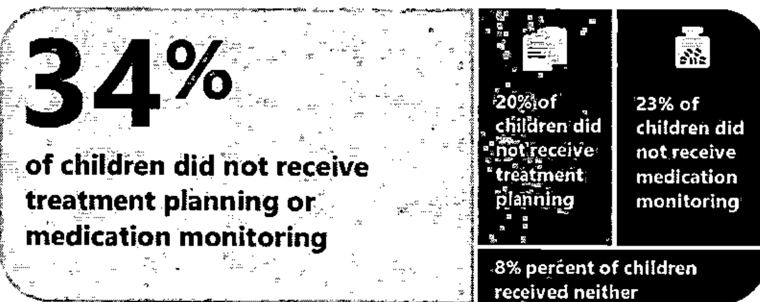
Treatment Planning and Medication Monitoring Were Lacking for Children in Foster Care Receiving Psychotropic Medication

What OIG Found

In five States, one in three children in foster care who were treated with psychotropic medications did not receive treatment planning or medication monitoring as required by States. Additionally, the Administration for Children and Families (ACF) has suggested that States consider practice guidelines from professional organizations, including the American Academy of Child and Adolescent Psychiatry, (AACAP) related to treatment planning and medication monitoring. We found that State requirements for oversight of psychotropic medication did not always incorporate these professional practice guidelines.

Treatment planning is critical to enhancing continuity of care; improving coordination of services between health and child welfare professionals; and reducing the risk of harmful side effects. Effective medication monitoring can reduce the risk of inappropriate dosing and inappropriate medication combinations.

Key Takeaway
The five States we reviewed partially complied with their own State requirements for treatment planning and medication monitoring for children in foster care receiving psychotropic medication. Improved compliance and stronger State requirements will help protect children who are at risk for inappropriate treatment and inappropriate prescribing practices.



What OIG Recommends

To ensure coordinated care for children in foster care who receive psychotropic medications, we recommend that ACF develop a comprehensive strategy to improve States' compliance with requirements related to treatment planning and medication monitoring for psychotropic medications. ACF should assist States in strengthening their requirements for oversight of psychotropic medications by incorporating suggested professional practice guidelines for monitoring children at the individual level. ACF stated that it concurred with some of our recommendations but not others; it did not specify which of the two formal recommendations it agreed with, and which it did not. OIG continues to recommend additional action by ACF as actions to date have not led to the needed outcomes.

Full report can be found at oig.hhs.gov/oei/reports/oei-07-15-00380.asp

Why OIG Did This Review

Up to 80 percent of children enter foster care with significant mental health needs. For children with mental health needs, psychotropic medications (i.e., medication used to treat clinical psychiatric symptoms or mental disorders such as depression, bipolar disorder, and schizophrenia) may be effective treatments. However, these medications can have serious side effects and, as ACF suggests and the five States in our sample require, should be used in conjunction with treatment planning mechanisms and effective medication monitoring.

A 2015 OIG report found—based on review of medical records—serious quality-of-care concerns in the treatment of children with psychotropic medications.

How OIG Did This Review

We selected a sample of 625 children in foster care from the 5 States that had the highest utilization of psychotropic medications in their foster care populations. On the basis of foster care case file documentation and Medicaid claims data, we determined the extent to which the children in our sample were treated with psychotropic medications in a manner consistent with their respective States' requirements. Additionally, we compared the five States' requirements for psychotropic medication oversight with treatment planning and medication monitoring practice guidelines from the American Academy of Child and Adolescent Psychiatry.

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BACKGROUND

Objectives

For the five States with the highest percentages of children in foster care treated with psychotropic medications:

1. to assess the extent to which children in foster care who were treated with psychotropic medications received treatment planning and medication monitoring consistent with States' requirements; and
2. to assess the extent to which States incorporate suggested professional practice guidelines for treatment planning and medication monitoring into their requirements for treatment of children with psychotropic medications.

In 2012, nearly 30 percent of the 400,000 children in foster care in the United States were taking at least one psychotropic medication.[1] Psychotropic medications are often used to treat clinical psychiatric symptoms or mental health disorders such as depression, bipolar disorder, schizophrenia, attention deficit/hyperactivity disorder (ADHD), post-traumatic stress disorder (PTSD), and anxiety disorders.[2, 3] Psychotropic medications can be effective treatments for children who have mental health needs, including children in foster care.[4] However, these medications can have serious side effects, such as drowsiness, weight gain, nausea, headaches, involuntary movements, and tremors, among others.[5] There is limited research to guide the use of psychotropic medications in children.[6] Therefore, psychotropic medications are to be used with care and as part of a comprehensive treatment plan.[7]

Many factors related to foster care can complicate efforts to provide appropriate mental health treatment. Up to 80 percent of children in foster care enter State custody with significant mental health needs.[8] Unlike children from intact families, children in foster care often do not have a consistent interested party to coordinate treatment planning or to provide continuous oversight of their mental health treatment.[9] Further, responsibility for children in foster care is shared among multiple people—foster parents, birth parents, and caseworkers—which creates risk of miscommunication, conflict, and lack of followup.[10] Children in foster care may also experience multiple changes in placement and in physicians, which can cause health information about these children to be incomplete and spread across many sources.[11] Therefore, children in foster care may be at risk for inappropriate prescribing practices (e.g., too many medications, incorrect dosage, incorrect duration, incorrect indications for use, or inappropriate treatment).[12]

Effective ongoing oversight of children's care and monitoring of prescribing patterns has several potential benefits, such as enhanced continuity of care, increased placement stability, reduced need for psychiatric hospitalization, and decreased incidence of adverse drug reactions and dangerous drug-to-drug interactions.[13] Ineffective monitoring may increase the risk for inappropriate dosing, frequent medication switches, or the use of inappropriate medication combinations.[14] For example, if a prescriber is unaware that medications are not being taken as ordered, the prescriber may conclude that the existing medication regimen is inadequate and increase a dose or add another medication.[15]

A March 2015 Office of Inspector General (OIG) report found that children enrolled in Medicaid—including children in foster care—experienced quality-of-care issues related to their treatment with antipsychotic medications, which are a type of psychotropic medication. Two of the common quality-of-care issues that we identified through reviewing medical records were related to treatment and monitoring.[16]

Medicaid pays for a majority of the healthcare services that children in foster care receive, including psychotropic medications.[17] In 2013, State Medicaid programs paid approximately $366 million for psychotropic medications for nearly 240,000 children in foster care up to age 21.[18]

The Administration for Children and Families' (ACF) Oversight of State Foster Care Program Requirements

ACF is responsible for awarding Federal funding to States' child welfare programs and for overseeing those programs.

ACF Requirements for State Plans. ACF requires the State agency that administers the State's child welfare program to submit a State plan every 5 years, which outlines how it will comply with Federal requirements. As part of its State plan submission, each State must include a healthcare coordination and oversight plan. The State child welfare agency develops this plan with the State Medicaid agency, pediatricians, other healthcare experts, child welfare service experts, and recipients of these services. The plan addresses the oversight of prescription medicines, including requirements for monitoring the appropriate use of psychotropic medications.[19, 20] The plan must address five elements (listed in Appendix A).[21] Annually, ACF requires each State child welfare agency to describe in its Annual Progress and Service Report its protocols (official procedures used to accomplish the State plan) related to each of the five elements and provide additional information on how the child welfare workforce and providers are trained with regard to these requirements.[22] Hereinafter, we refer to State agency as State and protocols as State requirements.

As noted earlier, previous OIG work has identified (through review of medical records) issues with children receiving inappropriate treatment and monitoring. Two of the five elements ACF requires to be part of a State's

plan include: (1) screening, assessment, and treatment planning mechanisms to identify children's mental health needs and trauma-treatment needs, including a psychiatric evaluation, as necessary, to identify whether children need psychotropic medications; and (2) effective medication monitoring at both the client level and agency level.[23] Client-level monitoring—in this case, child-level monitoring—refers to monitoring an individual who receives medication. Child-level monitoring can include practices such as employing nurses to ensure that individual children receive necessary services or requiring review of individual prescriptions.[24] Agency-level monitoring—in this case, State-level monitoring—refers to activities that support and inform decisions for all clients of an agency. State-level monitoring could involve a State's monitoring the rate at which children in foster care receive psychotropic medication, monitoring the types of psychotropic medications children receive, or establishing an advisory committee to oversee its medication formulary.[25]

ACF Oversight of State Compliance. ACF oversight includes periodic reviews of each State's child welfare system, known as Child and Family Services Reviews, to assess whether a State complies with its State plan requirements.[26] In this report, we refer to these reviews as compliance reviews. ACF determines compliance (i.e., substantial conformity) based on a number of factors, including the State's ability to meet criteria related to outcomes for children and families.[27] In making its assessment, ACF uses a compliance review instrument that assesses particular criteria and makes a determination based on the entirety of the review.

If ACF finds that a State is not in substantial conformity with its State plan, it requires that the State develop a program improvement plan.[28, 29] If the State fails to successfully complete a program improvement plan, ACF has the authority to withhold a certain amount of Federal funding.[30]

The mental/behavioral health section of the compliance review instrument includes an assessment of needs, and services that the State provided to meet those needs, for a sample of children in foster care. The instrument includes criteria such as (1) ensuring the child was seen regularly by the physician to monitor the effectiveness of medication, assess side effects, and consider any changes needed in dosage; (2) regularly following up with foster parents/caregivers about administering medications appropriately and outcomes and side effects.[31]

Guidance on Oversight of Psychotropic Medications for Children in Foster Care

ACF's instruction to States regarding development of requirements related to screening, assessment, treatment planning, and effective medication monitoring is broad. For example, ACF has not established requirements defining the periodicity of the screening, the assessment tools that should be used, or the details that should be included in the treatment plan.

ACF has suggested that States consider practice guidelines from professional organizations related to treatment planning and medication monitoring in efforts to improve their monitoring and oversight requirements of psychotropic medications. These organizations include the American Academy of Child and Adolescent Psychiatry (AACAP), the American Academy of Pediatrics, and prescription parameters developed by the State of Texas, which detail mechanisms that may be used to accomplish the broad requirements.[32] ACF highlighted the AACAP guidelines as particularly relevant to States when developing their psychotropic medication oversight and monitoring requirements. However, ACF instruction acknowledges that States are unique and does not mandate States to incorporate professional practice guidelines in their requirements.

Professional practice guidelines highlight the importance of treatment planning and medication monitoring for children prescribed psychotropic medications.[33] Treatment planning should include collaboration among caregivers to discuss symptoms, behaviors, and potential benefits and side effects of treatment options.[34] This allows all parties to understand why medication is being used and the plan for followup.[35] Medication monitoring visits should occur regularly to enhance patient and guardian confidence in the treatment, and to promote effective management of longer term treatment and safety issues.[36] Specifically, medication monitoring enables prescribing professionals, patients, and guardians to establish a plan for followup and reduce the risk for an unidentified relapse or recurrence of symptoms.[37]

Methodology

Scope

For five States, we determined whether children in foster care were treated with psychotropic medications consistent with their States' requirements related to: (1) screening, assessment, and treatment planning mechanisms, including (as necessary) psychiatric evaluations; and (2) medication monitoring. This study focuses on these two elements because of the quality-of-care concerns that we identified in previous OIG work.

We also determined the extent to which these State requirements were consistent with suggested professional practice guidelines focused on treatment of children with psychotropic medications.

In the States we reviewed, requirements related to screening and assessment applied only to children *entering* foster care. There was not a significant number of sampled children who entered foster care during the review period. Therefore, we were not able to project results related to screening and assessment requirements in the study.

Further, according to the States' requirements, psychiatric evaluations are required only "as necessary," or "if recommended." Because case files did not consistently document the need for psychiatric evaluation, we could not

assess compliance with this conditional requirement. Therefore, we were not able to project results related to psychiatric evaluation requirements.

State and Sample Selection

We selected the five States with the highest percentages of children in foster care who were treated with psychotropic medications in FY 2013, the most recent year for which there was complete data available in the Medicaid Statistical Information System (MSIS).[38] They were Iowa, Maine, New Hampshire, North Dakota, and Virginia.

We combined foster care eligibility data and Medicaid claims data obtained from the five States to determine the population of children in foster care treated with psychotropic medication during the review period, October 1, 2014, through March 31, 2015. From that population, we selected a simple random sample of 125 children from each of the 5 States, for a total of 625 children. We excluded 36 children for various reasons, such as the child's not having been in foster care for a sufficient time (see Appendix B).

Collection and analysis of documentation and data. For each child in our sample, we requested documentation from foster care case files and Medicaid claims data representing services received during the review period. We determined whether any services represented evidence that a required element—screening, assessment, treatment planning, psychiatric evaluation, and/or medication monitoring—occurred. For each instance of a requirement that the State appeared to have not met, we invited the State to provide additional evidence.

Comparing States' Requirements to Practice Guidelines Recommended by AACAP

ACF suggested States consider professional practice guidelines for improving their monitoring and oversight of psychotropic medications.[39] We selected professional practice guidelines from AACAP guidance documents for comparison with the five States' requirements for oversight regarding psychotropic medication.[40] See Appendix B for a detailed description of our methodology.

Limitations

Our estimates cannot be generalized beyond the five selected States.

It is possible that some children in our sample received healthcare services that were not paid for by Medicaid or were not included in the data submitted; therefore, this study may have underestimated the provision of required health services for these children.[41]

Standards

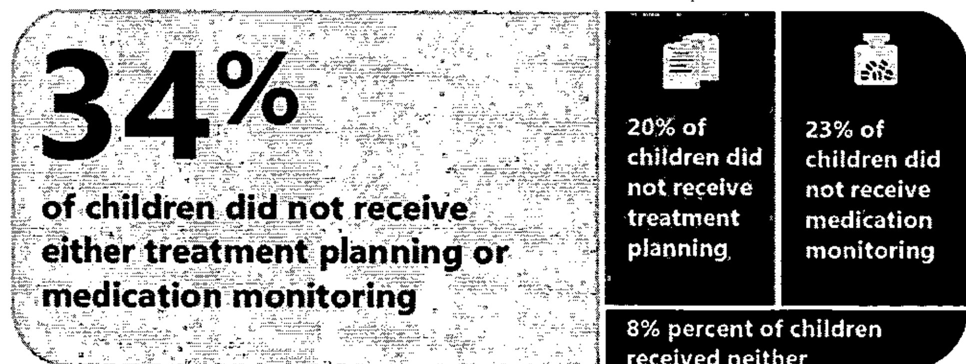
This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

One in three children in foster care who were treated with psychotropic medications did not receive required treatment planning or medication monitoring

Thirty-four percent of children in foster care who were treated with psychotropic medications, in the five States we reviewed, did not receive either treatment planning or medication monitoring (see Exhibit 1). Eight percent of these children received neither treatment planning nor medication monitoring. Treatment planning and effective medication monitoring are imperative because of the risks of inappropriate treatment and inappropriate prescribing practices (e.g., too many medications, incorrect dosage, incorrect duration, incorrect indications for use). See Appendix C for more information regarding States' compliance with each requirement we reviewed.

Exhibit 1: One in three children in foster care who were treated with psychotropic medications did not receive required treatment planning or medication monitoring



Note: Results are rounded.

Source: OIG analysis of State foster care case files and Medicaid claims for children in foster care, 2017.

See Appendix D for all point estimates and corresponding 95-percent confidence intervals.

Twenty percent of children in foster care did not receive treatment planning

In the five States reviewed, 20 percent of children did not receive treatment planning, as States required. Effective treatment planning provides a mechanism for caseworkers, foster parents, and prescribers to be aware of medications the child is receiving. For children in foster care, effective treatment planning is critical to enhancing continuity of care, improving coordination of services between health and child welfare professionals, and reducing the risk of harmful side effects.

In the following example, there was no evidence that a treatment plan was developed before starting the medication of a child in foster care. However, the child did receive a retrospective review of the four psychotropic medications prescribed. This review indicated concerns regarding the medical necessity of the child's drug regimen that should have been considered and documented in a treatment plan. Without a treatment plan, there is no evidence that the child's caregivers understood important concerns before medicating this child, such as (1) the rationale for each medication, (2) the potential benefits and side effects of each medication, and (3) the plan for followup.

Child Description—6-year-old child diagnosed with ADHD, behavior disorder, learning disability, tic disorder, dysarthria (speech disorder), oppositional defiant disorder, PTSD, trichotillomania (hair-pulling disorder). Prescribed four psychotropic medications.

Case Narrative—The State-employed nurse coordinator noted her opinion that the medications "were quite a bit for a child of his age," and initiated a referral for a medication review. The medication review indicated that the psychiatrist reviewer had questions regarding two of the four medications prescribed to this child. He acknowledged that current medication use could have been within the standard of care. However, there were questions concerning the following: (1) medical necessity for one of the medications; (2) side effects of one medication that could be exacerbating one of the child's conditions; and (3) a dosage increase in one medication that could have negated the need for the fourth medication. The medical review resulted in correspondence with the prescribing professional regarding the medical necessity for two of the child's four medications. Subsequent to this review, the child's drug regimen was changed.

In three of five States, over half of the children who received treatment planning did not have a complete treatment plan. Three of the five States have specific criteria for treatment plans. In those States, 52 percent of children who received treatment planning had plans that did not meet all State criteria. See Appendix C for each of the States' specific criteria for treatment plans, as well as the percentage of children for whom treatment plans did not meet all State-required criteria. Examples of State criteria for treatment plans in those three States include documentation of: diagnoses, assessment summaries, interventions, treatment progress, information about prescribed medications, and evidence of collaboration by a multidisciplinary team. Including these criteria in treatment plans helps caregivers to understand why medication is being used and the plan for followup. Further, treatment planning provides a mechanism for caregivers

to collaborate to assess target symptoms, behaviors, potential benefits, and adverse effects of treatment.

Twenty-three percent of children in foster care did not receive medication monitoring

In the five states we reviewed, 23 percent of children did not receive medication monitoring during the review period. Effective medication monitoring can reduce the risk of inappropriate dosing or inappropriate combinations of medications. For example, if a prescriber is unaware that medications are not provided as planned, the prescriber may unknowingly increase a dose or add another medication.

Medication monitoring is essential for children in foster care to promote communication among prescribing professionals, patients, and guardians, and to establish a plan for followup. Further, medication monitoring can reduce the risk for an unidentified recurrence of symptoms and promote effective management of longer term treatment and safety issues.

States acknowledged challenges in providing required services related to oversight of psychotropic medication for children in foster care

In the five States we reviewed, officials reported challenges in State plan implementation that can pose barriers to providing required services for children in foster care. These challenges included a lack of data for measuring outcomes and limited access to mental health services. Additionally, States noted that some gaps in meeting their requirements are related to transitions in the case-management workforce, developing effective accountability measures for caseworkers, and appropriate training for new caseworkers. Officials reported a need for additional guidance and technical assistance from ACF related to oversight of psychotropic medications prescribed to children in foster care.

States proposed some guidance and assistance that would be helpful to mitigate barriers to providing required services, including:

- national data for States to use as benchmarks in measuring their progress toward meeting the requirements;
- successful policy and practice strategies that have been used by other States to meet requirements; and
- assistance in improving communication between Medicaid and child welfare systems to facilitate the tracking of services provided to children in foster care and measure progress in meeting requirements.

State requirements for psychotropic medication oversight did not always incorporate suggested professional practice guidelines for treatment planning and medication monitoring

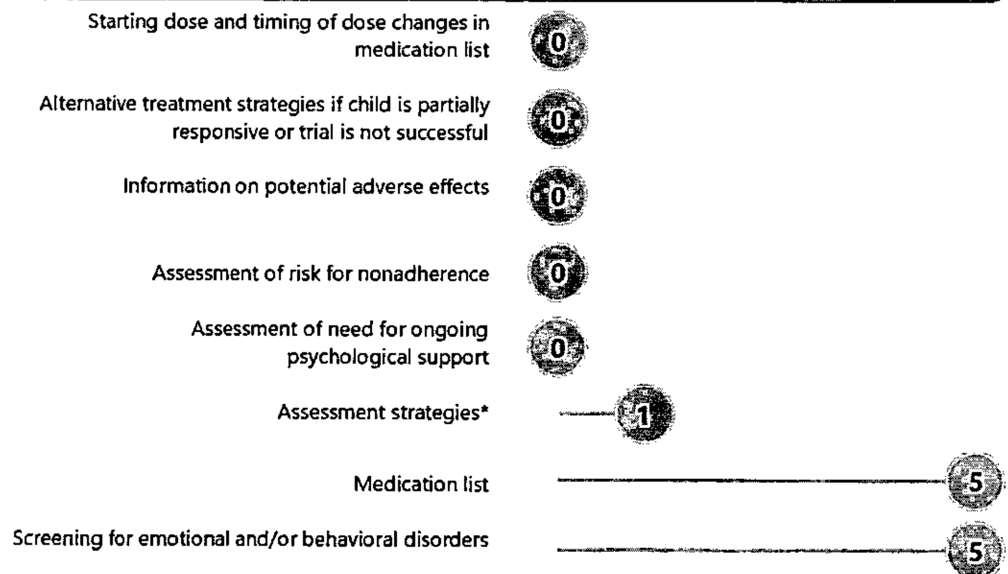
In the five States we reviewed, State requirements did not always incorporate professional practice guidelines regarding oversight of psychotropic medications for children in foster care, as suggested by ACF. Although ACF requires State plans to protect children by including treatment planning mechanisms and effective medication monitoring, it allows States flexibility in implementation. ACF suggests that States consider practice guidelines from professional organizations, including AACAP, to improve their treatment planning and medication monitoring requirements.

The five States' requirements did not consistently incorporate professional practice guidelines for child-level monitoring

Our review of five States found that State requirements did not always incorporate these recommendations related to child-level treatment planning and medication monitoring (see Exhibit 2). For example, none of the five States we reviewed included requirements to document medication dosages or potential adverse effects of medications within children's foster care case files.

Exhibit 2: States' requirements did not consistently incorporate elements of suggested professional practice guidelines for child-level oversight of psychotropic medication

Among five States, number that included suggested case file documentation requirements for child-level monitoring of psychotropic medications:



* For example, self-reports, parent or guardian reports, and teacher reports.
Source: OIG analysis of selected AACAP recommendations compared with States' requirements, 2017

Specifically, State child-level requirements did not include elements such as information on potential adverse effects or assessment of risk for nonadherence to the treatment plan. These elements provide essential information to accomplish effective oversight, to monitor prescribing, and

to enhance continuity of care. Without these child-level requirements, there is no mechanism to ensure that caregivers are consistently collaborating to assess target symptoms, behaviors, potential benefits, and adverse effects of treatment.

Child-level practice guidelines promote a coordinated strategy in oversight of individual children's psychotropic medication use. This guidance is critical due to known concerns in the foster care population, such as complex mental healthcare needs and changes in foster home placement. These concerns increase the risk of miscommunication among caregivers and ineffective and inappropriate medications or medication combinations. Additionally, previous work by the Government Accountability Office (GAO) concluded that States that do not incorporate AACAP's recommended elements limit their ability to identify potentially risky prescribing practices.[42]

The following example highlights the importance of State child-level requirements. In this State, there is no requirement for caseworkers to follow up with foster parents about medication and the child's outcomes or assess the risk for medication nonadherence. The child was without prescribed medication for a time and experienced adverse effects. There was no evidence in the case file that the caseworker was aware of the nonadherence and the impact on the child's outcome.

Child Description—11-year-old child diagnosed with reactive attachment disorder, conduct disorder, anxiety, and ADHD. Prescribed two psychotropic medications.

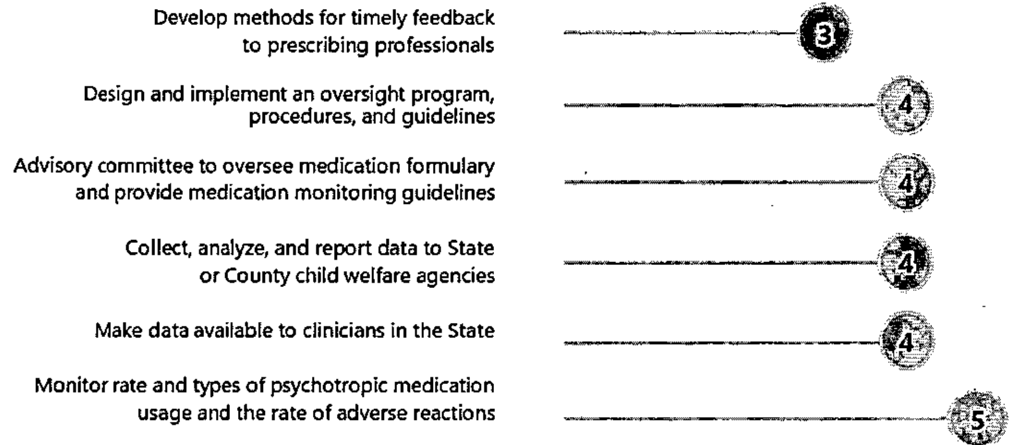
Case Narrative—The child experienced a 3-month period during which the foster mother stated she had difficulties obtaining medication refills for the child. Two prescribing professionals said the child needed to be seen first by a psychiatrist. One prescriber agreed to provide a refill because the child was unmanageable without medications. The child was seen by a psychiatrist during the fourth month, at which time the notes indicated the child was without medications, had lost the ability to maintain normal psychological function, and had experienced a decline of his overall situation. The decline included increased stealing, lying, bullying, poor interactions with other children, and in-school suspension.

The five States' requirements generally incorporated suggested professional practice guidelines for State-level monitoring

Unlike States' child-level requirements, States' State-level requirements generally incorporated suggested professional practice guidelines (see Exhibit 3, on the next page). For example, States included a requirement to monitor the rates and types of psychotropic medication usage and rates of adverse reactions. These aggregate mechanisms can improve States' ability

to identify potentially risky prescribing practices and to improve oversight of psychotropic medications for children in foster care.

Exhibit 3: States' requirements generally incorporated suggested professional practice guidelines for State-level oversight of psychotropic medication



Source: Source: OIG analysis of selected AACAP recommendations compared with States' requirements, 2017

CONCLUSION AND RECOMMENDATIONS

The five States that we reviewed partially complied with their own State-established requirements for treatment planning and medication monitoring for children in foster care receiving psychotropic medications; further, State requirements did not always include suggested professional practice guidelines designed to protect these children. Specifically, 34 percent of children in foster care who were treated with psychotropic medications did not receive treatment planning or medication monitoring as required. Additionally, States' requirements did not consistently incorporate suggested professional practice guidelines, such as requiring assessment strategies and documenting information on potential adverse effects. Improved compliance and strengthened State requirements are imperative to provide protections for children who are at risk for inappropriate treatment and inappropriate prescribing practices.

To ensure coordinated care for children in foster care receiving psychotropic medications, we recommend that ACF:

Develop a comprehensive strategy to improve States' compliance with requirements related to treatment planning and medication monitoring for psychotropic medication

ACF must ensure that States coordinate care for children in foster care with regard to oversight of psychotropic medication. To do this, ACF should develop a comprehensive strategy that identifies methods for States to improve compliance with requirements for treatment planning and medication monitoring. The strategy should guide ACF in strengthening compliance and identifying gaps that need to be addressed. This will improve transparency and accountability, and assist States in doing the same. The strategy should include, at a minimum:

- providing enhanced training and technical assistance, through collaboration with professional provider organizations, for States related to implementing treatment-planning mechanisms and effective medication monitoring (e.g., continued education for caseworkers and supervisors).

Also, ACF may consider:

- helping States develop effective accountability measures and mechanisms for internal quality review;
- requesting that States report data on treatment planning and medication monitoring to the extent they can provide reliable and consistent data, and then providing the compiled national data to States to use as a benchmark for their progress in meeting requirements; and

- placing increased weight on treatment planning and medication monitoring when determining a State's substantial conformity with plan requirements, changing the assessment instrument as necessary, and following up with enforcement actions when appropriate (e.g., mandating program improvement plans, and, where appropriate, withholding Federal funds).

Assist States in strengthening their requirements for oversight of psychotropic medication by incorporating professional practice guidelines for monitoring children at the individual level

ACF must help States strengthen their requirements by incorporating child-level protections for children in foster care who are treated with psychotropic medications. To do this, ACF should:

- strengthen its annual review of States' protocols to confirm that State requirements incorporate professional practice guidelines related to treatment planning and medication monitoring,
- publish an Information Memorandum regarding specific mechanisms for child-level treatment planning and methods to achieve effective medication monitoring, and
- provide enhanced training and technical assistance for States related to incorporating professional practice guidelines in State protocols through collaboration with professional provider organizations.

Also, ACF may consider:

- providing standardized protocols or templates that include child-level recommendations and implementation strategies that States could adapt to meet local needs.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

ACF stated that it concurred with some of our recommendations but not others; it did not specify which of the two formal recommendations it agreed with, and which it did not. ACF comments addressed various subsections of each of these recommendations. We ask that ACF clarify in its Final Management Decision its concurrence or non-concurrence for each formal recommendation.

OIG recommended that ACF develop a comprehensive strategy to improve States' compliance with requirements related to treatment planning and medication monitoring for psychotropic medication. In response, ACF noted that it already has a well-established approach to program implementation that includes a regulated mechanism to identify and correct compliance issues. However, OIG found that one in three children were not receiving treatment planning or medication monitoring, as required in their respective States, which suggests the current approach to identifying and correcting compliance issues is insufficient and more needs to be done. ACF did agree to assess opportunities to continue to provide technical assistance in this area as well as ensure States are reporting on this requirement through Child and Family Services Plans and annual updates. If ACF does conduct such technical assistance and training activities, in collaboration with professional organizations, this would fulfill the intent of our first recommendation.

However, we encourage ACF to further consider our additional suggestions toward improving States' treatment planning and medication monitoring for children in foster care. We note that ACF disagreed with one of these suggestions related to reporting data on treatment planning and medication monitoring. ACF views this data reporting to be outside the scope of what can be reliably and consistently reported to an administrative data set. ACF notes that, by law, its administrative data set must be both reliable and consistent across the reporting population. OIG agrees that data reporting must be reliable and consistent. We continue to encourage ACF to consider innovative approaches to promote State reporting of basic information on treatment planning and medication monitoring that will be reliable and consistent. Likewise, ACF could actively assist States to develop effective accountability measures and mechanisms for internal quality review and consider placing increased weight in its review of treatment planning and medication monitoring during its compliance reviews of States.

With respect to the second recommendation, OIG recommended that ACF assist States in strengthening their requirements for oversight of psychotropic medication. In response, ACF stated that it is amenable to assessing what additional technical assistance and best practice guidance to provide to States regarding the monitoring of psychotropic medication. ACF described the mechanisms through which it makes technical assistance available to States and noted that, to date, no States have reached out around this area of need. ACF also stated that the Child Welfare Information Gateway will include a new article on improving the use of psychotropic medication for children in foster care. This article may represent a step toward providing technical assistance for States related to incorporating professional practice guidelines in State protocols, one aspect of OIG's recommendation. However, overall, ACF's response did not address the substance of OIG's recommendation. OIG continues to recommend that ACF actively engage with States through various actions. In addition to providing technical assistance, these actions should include strengthening its annual review of States' protocols to confirm that State requirements incorporate professional practice guidelines related to treatment planning and medication monitoring for children at the individual level.

The full text of ACF's comments can be found in Appendix F.

APPENDIX A: Five Required Elements for Monitoring the Appropriate Use of Psychotropic Medications

ACF program instruction directs States to include the following elements in their protocols:

1. comprehensive and coordinated screening, assessment, and treatment planning mechanisms to identify children's mental health and trauma-treatment needs, including a psychiatric evaluation, as necessary, to identify needs for psychotropic medications; and
2. informed and shared decision making and methods for ongoing communication between the prescriber, the child, the child's caregivers, and other stakeholders (e.g., healthcare providers and child welfare worker);
3. effective medication monitoring at both the client level and agency level;
4. availability of mental health expertise and consultation regarding both consent and monitoring issues by a board-certified child and adolescent psychiatrist; and
5. mechanisms for sharing accurate and up-to-date information related to psychotropics with clinicians, child welfare staff, and consumers (e.g., children and caregivers), including both data sharing mechanisms (e.g., integrated information systems) and methods for sharing educational materials.[43]

APPENDIX B: Detailed Methodology

State Selection

We selected the five States with the highest percentages of children in foster care who were treated with psychotropic medications in FY 2013. Our assessment of Medicaid eligibility and claims data determined they were Iowa, Maine, New Hampshire, North Dakota, and Virginia. Appendix E contains further details on demographics and Medicaid fee-for-service (FFS) expenditures in all States.

Exhibit B-1: State Demographics Regarding Children in Foster Care Treated with Psychotropic Medications and Related Medicaid Expenditures

State	Population of Children in Foster Care	Number of Children in Foster Care Treated with Psychotropic Medications	Percentage of Children in Foster Care Treated with Psychotropic Medications	Total Medicaid FFS Expenditures for Psychotropic Medications for Children in Foster Care
Iowa	13,951	4,981	35.7%	$7,135,849
Maine	3,527	1,155	32.7%	$1,600,692
New Hampshire	2,614	944	36.1%	$1,741,581
North Dakota	2,734	1,021	37.3%	$1,184,934
Virginia	14,999	5,584	37.2%	$11,959,404

Source: OIG analysis of MSIS eligibility and prescription drug claims data, 2016.

Collection of States' Data and Requirements

We sent a letter to the administrator of each selected State's foster care agency and to each Medicaid director to request a point of contact to respond to our requests for information. From the points of contact, we requested: (1) foster care eligibility data representing all children enrolled in foster care at any time during the review period; (2) a copy of the State's selected foster care requirements; (3) any supporting documentation accompanying those requirements (such as State policies or required forms); (4) State responses to questions that the team developed regarding how the State has implemented the requirements and any related guidance and technical assistance ACF has provided; and (5) all Medicaid-paid claims for psychotropic medications prescribed to children up to 21 years old between October 1, 2014, and March 31, 2015, from the States' Medicaid Management Information Systems (MMIS).

Sample Selection

We selected a simple random sample of 125 children from each State for a total of 625 children. A total of 36 children were determined to be ineligible

for the sample for one of the following reasons: the child was not in foster care during the review period, the child did not receive a Medicaid-paid psychotropic drug claim during their foster care eligibility or during our review period, the child was not in foster care for at least 30 days of our review period, or other limitations prevented review of the case file. Therefore, the overall weighted response rate was 92 percent. In total, 589 children were analyzed for this review. See Exhibit B-2 below regarding the population and sample sizes for the five States.

Exhibit B-2: Population of Children in Foster Care Enrolled in Medicaid Treated with Psychotropic Medications at Any Time Between October 1, 2014, and March 31, 2015

State	Population Size	Sample Size	Ineligible Sampled Children	Final Analyzed Sampled Children
Iowa	2,166	125	9	116
Maine	566	125	5	120
New Hampshire	244	125	1	124
North Dakota	280	125	7	118
Virginia	2,156	125	14	111
Total	5,412	625	36	589

Source: OIG analysis of State foster care case files and Medicaid claims for children in foster care, 2017.

Case File Documentation and Medicaid Claims Data Review

We developed criteria based on the State's selected requirements related to screening, assessment, treatment planning, medication monitoring, and psychiatric evaluation. Using the foster care case file documentation and Medicaid claims data, we reviewed each child's treatment with psychotropic medications according to the State's requirements. For our study period, October 1, 2014 to March 31, 2015, we identified the case file documentation and healthcare services received by each child during the child's foster care eligibility. We then determined whether any of those services represented a required element.

For medication monitoring with a prescribing professional, any Medicaid claim for an evaluation and management visit with a mental health diagnosis was considered to fulfill this requirement.[44] Any documentation in the case file stating that an appointment occurred was considered to have fulfilled this requirement so long as we could determine it was with a prescribing professional or the child's psychotropic medication(s) were discussed. Caseworker notes, narrative, or emails that summarized changes in medication were also considered medication monitoring.

Because States gave minimal definition of treatment plans, we considered any case file documentation that was labeled "treatment plan," "case plan," or "care plan" to have fulfilled the treatment plan requirement.[45] Plans developed by prescribing professionals and/or by foster care caseworkers

were considered to have fulfilled this requirement. Documents developed by schools were not considered to have fulfilled treatment plan requirements.

Analysis of Results

We reviewed foster care case file documentation and Medicaid claims data for each sampled child. If either foster care case file documentation or the Medicaid claims demonstrated receipt of a particular required element by a sampled child, that element was counted as received. If neither the foster care case file documentation nor the Medicaid claims demonstrated receipt of a particular required element by a sampled child, that element was counted as not received.

We followed up with foster care program officials in the five States regarding every child for whom we determined at least one required element was missing. State officials either provided additional documentation showing that the child did receive the element(s) in question, or declined to submit additional documentation. If additional documentation showed that the element(s) were received, we counted those element(s) as received.

Comparing States' Protocols to Professional Practice Guidelines

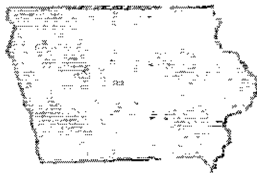
We selected professional practice guidelines from AACAP guidance documents for comparison with the five States' requirements for oversight regarding psychotropic medication. Specifically, we selected professional practice guidelines related to (1) screening, assessment, psychiatric evaluations, and treatment planning; and (2) medication monitoring. We then assessed the extent to which State requirements incorporated these professional practice guidelines. For example, regarding treatment planning and medication monitoring, we assessed whether States' protocols required inclusion of elements such as assessment for risk of nonadherence, information on adverse effects, assessment strategies, starting dose and timing of dose changes in the medication list.

APPENDIX C: State-by-State Compliance With Psychotropic Medication Requirements

This appendix contains five State-by-State summaries of compliance for selected foster care requirements regarding psychotropic medications.

We reviewed foster care case file documentation and Medicaid claims data representing healthcare services and mental health services received by the sampled children during the review period. We determined whether any of those documents or claims represented evidence that a State-required criteria of treatment planning and medication monitoring was provided.

Each State establishes its own foster care requirements (i.e., protocols) for oversight of psychotropic medications. Each State's requirements are unique; therefore, the criteria that we used to assess consistency with the requirements in each selected State is unique to that State. Additionally, we included a determination for each State of whether each sampled child received medication monitoring by a prescribing professional.



Iowa

Compliance with State-Specific Requirements Based on Foster Care Case File and Medicaid Claims Review

TREATMENT PLANNING

Iowa requires that a treatment plan be developed for the child in foster care.

- 30 percent of children in foster care did not receive a treatment plan

MEDICATION MONITORING

Iowa requires caseworkers to visit children in foster care monthly to: determine whether children are receiving necessary medical care and whether the program plan is providing appropriate and sufficient services; inquire of the foster family the effectiveness of the medications; and document the child's medications, why they were prescribed, and whether they meet the child's needs. We also included a determination of whether each sampled child received medication monitoring by a prescribing professional.

- Children in foster care did not receive the following State-required medication monitoring criteria, as applicable:*
    - 41 percent of children did not have evidence that the caseworker documented whether the child was receiving necessary medical care in their case files
    - 33 percent of children did not have evidence that the caseworker documented whether the program plan was providing appropriate and sufficient services in their case files
    - 83 percent of children did not have evidence that the caseworker inquired of the foster family the effectiveness of the medications in their case files
    - 84 percent of children did not have evidence that the caseworker documented the reason the medication was prescribed in their case files
    - 72 percent of children did not have evidence that the caseworker documented whether the medication was meeting the child's needs in their case files
- 48 percent of children in foster care did not receive medication monitoring by a prescribing professional

HIGHLIGHT OF RELATED STATE PRACTICES

Iowa requires caseworkers to conduct multiple tasks related to medication monitoring during their monthly visits with children in foster care. Tasks include determining whether a child is receiving necessary medical care, inquiring of the foster family the effectiveness of a medication, and determining whether the medication meets the child's needs.

Source: OIG analysis of State foster care case files and Medicaid claims for children in foster care, 2017.
*The figures in this exhibit represent the occurrence of this activity at least once during the review period. However, we note Iowa protocol directs caseworker to complete these tasks monthly.

Maine

Compliance with State-Specific Requirements Based on Foster Care Case File and Medicaid Claims Review

TREATMENT PLANNING

Maine requires that a treatment plan be developed for the child in foster care.

- 28 percent of children in foster care did not receive a treatment plan

MEDICATION MONITORING

Maine requires that children in foster care's medication plans be reviewed quarterly by the treatment provider. Additionally, for children prescribed antipsychotic medication, Maine requires the caseworker to participate in medical or psychiatric appointments where medications are initially discussed and a determination is made to proceed or not, and then at least every 3 months following. We also included a determination of whether each sampled child received medication monitoring by a prescribing professional.

- 26 percent of children in foster care had a medication plan that was not reviewed quarterly by the treatment provider
- For children prescribed antipsychotic medications, 59 percent of children in foster care did not have a caseworker who participated in initial medical or psychiatric appointments and then at least every 3 months following*
- 11 percent of children in foster care did not receive medication monitoring by a prescribing professional

HIGHLIGHT OF RELATED STATE PRACTICES

Maine requires caseworkers to conduct certain tasks when a prescribing professional considers antipsychotic medications as a course of treatment for a child in foster care. Caseworkers must provide the child with a discussion guide on antipsychotic medications, complete a medication consent form, review the child's case with the prescribing professional, and participate in the initial appointment to discuss the medication and then every three months following.

Source: OIG analysis of State foster care case files and Medicaid claims for children in foster care, 2017.
*This estimate is based on a sample size of 39 children. The 95-percent confidence interval for this estimate is 45 percent to 72 percent.

New Hampshire

Compliance with State-Specific Requirements Based on Foster Care Case File and Medicaid Claims Review

TREATMENT PLANNING

New Hampshire requires that a treatment plan be developed for the child in foster care. The treatment plan must include an assessment summary, diagnosis, goals or desired outcomes, incremental steps to goal achievement, interventions, an evaluator's name or signature, and a date.

- 23 percent of children in foster care did not receive a treatment plan
- 76 percent of children in foster care did not receive all State-required treatment planning criteria, as follows:
  - 6 percent of children did not have an assessment summary in their treatment plan
  - 38 percent of children did not have a diagnosis in their treatment plan
  - 3 percent of children did not have goals or desired outcomes in their treatment plan
  - 7 percent of children did not have incremental steps to goal achievement in their treatment plan
  - 6 percent of children did not have interventions in their treatment plan
  - 57 percent of children did not have the evaluator's name/signature/date in their treatment plan

MEDICATION MONITORING

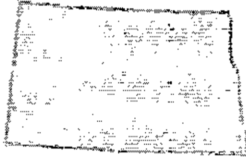
We included a determination of whether each sampled child received medication monitoring by a prescribing professional.

- 22 percent of children in foster care did not receive medication monitoring by a prescribing professional

HIGHLIGHT OF RELATED STATE PRACTICES

New Hampshire employs public health nurse coordinators to assist caseworkers by coordinating healthcare visits, exams and treatment for children in foster care, reviewing healthcare histories, and documenting care planning activities.

Source: OIG analysis of State foster care case files and Medicaid claims for children in foster care, 2017.



North Dakota

Compliance with State-Specific Requirements Based on Foster Care Case File and Medicaid Claims Review

TREATMENT PLANNING

North Dakota requires that a treatment plan be developed for the child in foster care. The plan must include goals or objectives, action steps, information about prescribed medications, documentation of treatment progress, and evidence that the treatment plan was developed by a multidisciplinary team.*

- 7 percent of children in foster care did not receive a treatment plan
- 38 percent of children in foster care did not receive all State-required treatment planning criteria, as follows:
  - 2 percent of children did not have goals or objectives in their treatment plan
  - 8 percent of children did not have action steps for meeting specified goals in their treatment plan
  - 11 percent of children did not have information about prescribed medications in their treatment plan
  - 11 percent of children did not have documentation of treatment progress in their treatment plan
  - 27 percent of children did not receive a treatment plan developed by a multidisciplinary team

MEDICATION MONITORING**

We included a determination of whether each sampled child received medication monitoring by a prescribing professional.

- 2 percent of children in foster care did not receive medication monitoring by a prescribing professional

HIGHLIGHT OF RELATED STATE PRACTICES

North Dakota requires multidisciplinary participation in Child & Family Team meetings for children in foster care. The teams are tasked with reviewing case plans, determining levels of care, writing permanency plans, and developing local policies related to foster care.

Source: OIG analysis of State foster care case files and Medicaid claims for children in foster care, 2017.
*North Dakota protocol does not define the disciplines included in a multidisciplinary team. For this review, we considered this requirement met with evidence of participation by at least two disciplines including: Guardian Ad Litem (GAL), Independent Living Coordinator, social worker, caseworker, practitioner, and therapist.
**North Dakota medication monitoring requirements applied to children in foster care in certain circumstances (e.g., residential treatment facilities and therapeutic foster care). These requirements were not applicable to a significant number of sampled children; therefore, we cannot project compliance with these requirements.

Virginia

Compliance with State-Specific Requirements Based on Foster Care Case File and Medicaid Claims Review

TREATMENT PLANNING

Virginia requires that a treatment plan be developed for the child in foster care. The plan must include the child's strengths and needs, health status including any allergies or health conditions, names and addresses of the child's medical and mental health providers, and a list of the child's medications including psychotropic drugs.

- 7 percent of children in foster care did not receive a treatment plan
- 52 percent of children in foster care did not receive all State-required treatment planning criteria, as follows:
    - 12 percent of children did not have strengths and needs in their treatment plan
    - 25 percent of children did not have health status in their treatment plan
    - 42 percent of children did not have the names and addresses of their medical and mental health providers in their treatment plan
    - 29 percent of children did not have a list of their medications including psychotropic drugs in their treatment plan

MEDICATION MONITORING

We included a determination of whether each sampled child received medication monitoring by a prescribing professional.

- 3 percent of children in foster care did not receive medication monitoring by a prescribing professional

HIGHLIGHT OF RELATED STATE PRACTICES

Virginia's Department of Social Services revised the State's foster care manual in July 2015. Updates included requirements for caseworkers to discuss psychotropic medications with the child and guardian, identify the person in the home responsible for administering and monitoring the medication, communicate the importance of medication adherence, monitor the child's behavior, and report any side effects.

Source: OIG analysis of State foster care case files and Medicaid claims for children in foster care, 2017.

APPENDIX D: Statistical Estimates and Confidence Intervals

Exhibit D-1 contains:

- sample sizes (the number of sample children where we obtained useable outcomes);
- point estimates (made using the outcomes determined on the basis of the number of sample children reviewed, or the sample size); and
- 95-percent confidence intervals (estimates of the error in the point estimates; 95 percent is a strong level of confidence).

Exhibit D-1: Point Estimates, Sample Sizes, and Confidence Intervals

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Five States combined statistics			
Percent of children in foster care treated with psychotropic medications that did not receive treatment planning or medication monitoring	589	33.9%	29.8%–38.3%
Percent of children who did not receive a treatment plan	589	19.5%	15.9%–23.6%
Percent of children who did not receive medication monitoring	589	22.9%	19.2%–27.0%
Percent of children who did not receive treatment planning and medication monitoring	589	8.4%	6.0%–11.7%
In States with specific treatment plan requirements, percent of children who received a treatment plan that did not receive all State-required treatment planning criteria	308	52.0%	44.4%–59.6%
Iowa's specific requirements			
Percent of children who did not receive a treatment plan	116	30.2%	22.7%–38.9%
Percent of children who did not have evidence that the caseworker documented whether the child was receiving necessary medical care in their case files	116	40.5%	32.2%–49.5%
Percent of children who did not have evidence that the caseworker documented whether the program plan was providing appropriate and sufficient services in their case files	116	32.8%	25.0%–41.6%

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Exhibit D-1: Point Estimates, Sample Sizes, and Confidence Intervals (continued)

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Iowa's specific requirements			
Percent of children who did not have evidence that the caseworker inquired of the foster family the effectiveness of the medications in their case files	116	82.8%	75.0%–88.5%
Percent of children who did not have evidence that the caseworker documented the reason the medication was prescribed	116	83.6%	76.0%–89.2%
Percent of children who did not have evidence that the caseworker documented whether the medication was meeting the child's needs	116	72.4%	63.8%–79.6%
Percent of children who did not receive medication monitoring by a prescribing professional	116	48.3%	39.5%–57.1%
Maine's specific requirements			
Percent of children who did not receive a treatment plan	120	27.5%	21.0%–35.1%
Percent of children who did not have their medication plan reviewed quarterly by their treatment provider	120	25.8%	19.5%–33.4%
Percent of children prescribed antipsychotic medication who had no evidence that the caseworker participated in medical or psychiatric appointments where medications were initially discussed and a determination is made to proceed or not, and then at least every 3 months following*	39	59.0%	44.9%–71.7%
Percent of children who did not receive medication monitoring by a prescribing professional	120	10.8%	6.8%–16.8%
New Hampshire's specific requirements			
Percent of children who did not receive a treatment plan	124	23.4%	18.6%–29.0%
Percent of children who did not receive all State-required treatment planning criteria	95	75.8%	69.2%–81.3%
Percent of children who did not have an assessment summary in their treatment plan	95	6.3%	3.6%–10.8%
Percent of children who did not have a diagnosis in their treatment plan	95	37.9%	31.3%–44.9%
Percent of children who did not have goals or desired outcomes in their treatment plan	95	3.2%	1.4%–6.8%

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Exhibit D-1: Point Estimates, Sample Sizes, and Confidence Intervals (continued)

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
New Hampshire's specific requirements			
Percent of children who did not have incremental steps to goal achievement in their treatment plan	95	7.4%	4.4%–12.0%
Percent of children who did not have interventions in their treatment plan	95	6.3%	3.6%–10.8%
Percent of children who did not have the evaluator's name/signature/date in their treatment plan	95	56.8%	49.8%–63.7%
Percent of children who did not receive medication monitoring by a prescribing professional.	124	21.8%	17.1%–27.3%
North Dakota's specific requirements			
Percent of children who did not receive a treatment plan	118	6.8%	4.1%–11.1%
Percent of children who did not receive all State-required treatment planning criteria	110	38.2%	31.7%–45.2%
Percent of children who did not receive goals or objectives in their treatment plan	110	1.8%	0.6%–5.0%
Percent of children who did not receive action steps for meeting specified goals in their treatment plan	110	8.2%	5.1%–12.9%
Percent of children who did not receive information about prescribed medications in their treatment plan	110	10.9%	7.3%–16.1%
Percent of children who did not receive documentation of treatment progress in their treatment plan	110	10.9%	7.3%–16.1%
Percent of children who did not receive a treatment plan developed by a multidisciplinary team	110	27.3%	21.5%–33.9%
Percent of children who did not receive medication monitoring by a prescribing professional	118	1.7%	0.6%–4.7%

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Exhibit D-1: Point Estimates, Sample Sizes, and Confidence Intervals (continued)

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Virginia's specific requirements			
Percent of children who did not receive a treatment plan	111	7.2%	3.7%–13.6%
Percent of children who did not receive all State-required treatment planning criteria	103	51.5%	42.1%–60.7%
Percent of children who did not receive strengths or needs of the child in their treatment plan	103	11.7%	6.8%–19.2%
Percent of children who did not receive a health status, including any allergies or health conditions in their treatment plan	103	25.2%	17.9%–34.3%
Percent of children who did not receive the names and addresses of child's medical and mental health providers in their treatment plan	103	41.7%	32.8%–51.2%
Percent of children who did not receive a list of the child's medications including psychotropic drugs in their treatment plan	103	29.1%	21.3%–38.4%
Percent of children who did not receive medication monitoring by a prescribing professional	111	2.7%	0.9%–7.8%

Source: OIG analysis of State foster care case files and Medicaid claims for children in foster care, 2017.
*We are unable to reliably project the frequency estimates for this item because of the small number of sample occurrences.

APPENDIX E: State Demographics Regarding Children in Foster Care Treated With Psychotropic Medications

For each State, Exhibit E-1 represents the population of children in foster care,[46] the number and percentage of children in foster care who were treated with psychotropic medications,[47] and total Medicaid FFS expenditures for psychotropic medications for children in foster care in FY 2013. These figures are based on MSIS eligibility and prescription drug claims data. For States that cover medications through managed care, the exhibit does not reflect the amounts the managed care organizations (MCOs) paid for psychotropic medications for children in foster care.[48] States such as Arizona and Hawaii do not have FFS expenditures for these drugs because they were all covered through managed care.

Exhibit E-1: State Demographics Regarding Children in Foster Care Treated with Psychotropic Medications and Related Medicaid Expenditures*

State	Population of Children in Foster Care	Number of Children in Foster Care Treated with Psychotropic Medications	Percentage of Children in Foster Care Treated with Psychotropic Medications	Total Medicaid FFS Expenditures for Psychotropic Medications for Children in Foster Care
Alabama	11,709	2,897	24.7%	$4,851,356
Alaska	4,175	672	16.1%	$1,204,665
Arizona	24,731	4,257	17.2%	$0
Arkansas	9,857	2,470	25.1%	$3,415,546
California	147,806	20,064	13.6%	$44,581,405
Colorado	21,155	4,871	23.0%	$9,116,770
Connecticut	5,674	1,532	27.0%	$3,345,982
Delaware	2,254	719	31.9%	$1,465,037
District of Columbia	4,671	613	13.1%	$1,026,092
Florida	65,198	11,228	17.2%	$16,510,753
Georgia	33,033	9,408	28.5%	$12,021,956
Hawaii	5,912	571	9.7%	$0
Idaho**	5,024	1,102	21.9%	$1,515,443
Illinois	53,898	10,109	18.8%	$10,733,426
Indiana	23,912	6,844	28.6%	$14,371,841
Iowa	13,951	4,981	35.7%	$7,135,849

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Exhibit E-1: State Demographics Regarding Children in Foster Care Treated with Psychotropic Medications and Related Medicaid Expenditures* (continued)

State	Population of Children in Foster Care	Number of Children in Foster Care Treated with Psychotropic Medications	Percentage of Children in Foster Care Treated with Psychotropic Medications	Total Medicaid FFS Expenditures for Psychotropic Medications for Foster Children
Kansas	18,319	4,292	23.4%	$3,230,278
Kentucky	18,257	5,657	31.0%	$494,659
Louisiana	13,407	4,017	30.0%	$5,584,262
Maine	3,527	1,155	32.7%	$1,600,692
Maryland	16,030	4,450	27.8%	$9,441,087
Michigan	18,884	4,190	22.2%	$10,193,641
Minnesota	12,446	3,597	28.9%	$4,094,907
Mississippi	7,294	1,891	25.9%	$3,187,730
Missouri	34,817	9,847	28.3%	$26,130,684
Montana	4,861	1,249	25.7%	$2,336,576
Nebraska	13,606	3,882	28.5%	$7,118,577
Nevada	12,100	1,829	15.1%	$3,431,784
New Hampshire	2,614	944	36.1%	$1,741,581
New Jersey	27,856	3,871	13.9%	$387,902
New Mexico	6,450	1,189	18.4%	$53,857
New York	54,099	9,068	16.8%	$9,671,915
North Carolina	23,121	7,004	30.3%	$16,393,851
North Dakota	2,734	1,021	37.3%	$1,184,934
Ohio	35,029	9,196	26.3%	$23,575,138
Oklahoma	11,120	2,267	20.4%	$3,150,116
Oregon	23,331	4,468	19.2%	$4,812,840
Pennsylvania	54,349	11,387	21.0%	$1,377,212
Rhode Island**	4,875	979	20.1%	$178,257
South Carolina	14,087	3,630	25.8%	$3,794,339
South Dakota	4,709	1,304	27.7%	$2,480,728
Tennessee	24,455	6,418	26.2%	$11,017,546
Texas	88,609	23,991	27.1%	$35,762,195
Utah	10,862	3,212	29.6%	$7,954,880
Vermont	2,950	933	31.6%	$1,915,196

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Exhibit E-1: State Demographics Regarding Children in Foster Care Treated with Psychotropic Medications and Related Medicaid Expenditures* (continued)

State	Population of Children in Foster Care	Number of Children in Foster Care Treated with Psychotropic Medications	Percentage of Children in Foster Care Treated with Psychotropic Medications	Total Medicaid FFS Expenditures for Psychotropic Medications for Foster Children
Virginia	14,999	5,584	37.2%	$11,959,404
Washington	27,538	5,035	18.3%	$7,008,379
West Virginia	10,950	3,138	28.7%	$4,163,156
Wisconsin	18,290	4,557	24.9%	$7,289,062
Wyoming	3,805	875	23.0%	$1,542,474
Total:	**1,073,340**	**238,465**	**22.2%**	**$365,555,960**

Source: OIG analysis of MSIS eligibility and prescription drug claims data, 2016.

*Massachusetts is not included in this exhibit because its MSIS eligibility files for FY 2013 were incomplete. The Massachusetts eligibility data included only approximately 1,500 unique identifiers for children in foster care. The population of children in foster care in Massachusetts is known to be significantly higher than 1,500.

**Indicates that complete FY 2013 data was not available in MSIS at the time of data collection; therefore, FY 2012 data was used.

APPENDIX F: Agency Comments

ADMINISTRATION FOR
CHILDREN & FAMILIES

Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, D.C. 20201 | www.acf.hhs.gov

07/27/2018

Ms. Suzanne Murrin
Deputy Inspector General for Evaluation and Inspections
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Ms. Murrin:

I am writing to you concerning the Office of Inspector General's (OIG) draft report: *Treatment Planning and Medication Monitoring were Lacking for Children in Foster Care Receiving Medication (Report OEI-07-15-00380).* ACF concurs with some of the OIG's recommendations but not others for the reasons set forth below.

Recommendation 1:
ACF develop a comprehensive strategy to improve State's compliance with requirements related to treatment planning and medication monitoring for psychotropic medications.

ACF Response:
We appreciate the OIG's examination of several states with respect to issues in the implementation of their protocols for the appropriate use and monitoring of psychotropic medications.

As far as establishing a strategic plan specific to this requirement, ACF has a well-established approach to program implementation. No approach can guarantee that compliance issues will not arise. Our approach includes a regulated mechanism to identify and correct any compliance issues. OIG's recommendation would require statutory and regulatory changes to implement.

ACF currently collects administrative data but views data on treatment planning and medication monitoring to be outside the scope of what can be reliably and consistently reported to an administrative data set. The statute requires any data reported to our administrative data set be both reliable and consistent across the reporting population.

We will assess opportunities to continue to provide technical assistance in this area as well as ensure states are reporting on this requirement through the Child and Family Services Plans and its annual updates.

Recommendation 2:
ACF should assist States in strengthening their requirements for oversight of psychiatric medications by incorporating suggested professional practice guidelines for monitoring children at the individual level.

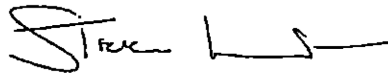
Page 2 – Ms. Gloria L. Jarmon

ACF Response:
We are amenable to assessing what additional technical assistance and best practice guidance to provide to states. Let me first highlight how our current technical assistance is structured. The Child Welfare Information Gateway (Information Gateway) develops, disseminates and maintains publications, website pages, general information and guidance on a variety of child welfare topics, including those focused on effectively addressing ongoing challenges related to ensuring the appropriate use of psychotropic medications for children in foster care. The Capacity Building Center for States (Center) seeks to support State and territorial child welfare agencies in building capacity to better serve youth by undertaking efforts and promoting best practices, including those related specifically to psychotropic medication use for children in foster care and accompanying topics such as health and mental health, well-being, continuity of care, and successful transitions to adulthood. Services are available to respond to state-specific needs related to the oversight of psychotropic medications for children in foster care and may involve policy and procedure development, consultation and training design, as well as support for the implementation of related efforts. To date, no state has engaged the Center specifically around this area of need.

We do continue, however, to highlight resources for states as they are developed and as they come to our attention. In July/August 2018 the Information Gateway will spotlight new information on mental health of children and youth in foster care, specifically an article titled, "Improving the Use of Psychotropic Medication for Children in Foster Care: A Resource Center," by the Center for Health Care Strategies, Inc.

In conclusion, ACF believes that while we have statutory and regulatory constraints that prevent us from fully implementing all of OIG's recommendations, we will take full advantage of our technical assistance resources to be responsive to OIG's findings in this report. Please direct any follow-up inquires to Scott Logan of our Office of Legislative Affairs and Budget at (202) 401-4529.

Sincerely,



Steven Wagner
Acting Assistant Secretary
for Children and Families

ACKNOWLEDGMENTS

Jamila Murga served as the team leader for this study, and Dana Squires and Abbi Warmker served as lead analysts. Others in the Office of Evaluation and Inspections who conducted the study include Cody Johnson, Katie Fry, Lesta Newberry, Anna Pechenina, and Andrea Staples. Office of Evaluation and Inspections central office staff who provided support include Althea Hosein and Seta Hovagimian.

This report was prepared under the direction of Brian T. Whitley, Regional Inspector General for Evaluation and Inspections in the Kansas City regional office, and Jennifer E. King, Deputy Regional Inspector General.

To obtain additional information concerning this report or to obtain copies, contact the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

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ENDNOTES

[1] ACF, *Managing Psychotropic Medications for Children and Youth in Foster Care*, 2012. Accessed at http://www.acf.hhs.gov/blog/2012/08/managing-psychotropic-medications-for-children-and-youth-in-foster-care on April 1, 2016.
[2] Centers for Disease Control, *Psychotropic Medication Use Among Adolescents: United States, 2005-2010*, 2013. Accessed at https://www.cdc.gov/nchs/data/databriefs/db135.pdf on July 5, 2017.
[3] National Institute of Mental Health, *Mental Health Medications*, 2016. Accessed at http://www.nimh.nih.gov/health/topics/mental-health-medications/index.shtml on March 31, 2016.
[4] ACF, Information Memorandum ACYF-CB-IM-12-03, 2012. Accessed at https://www.acf.hhs.gov/sites/default/files/cb/im1203.pdf on August 24, 2017.
[5] National Institute of Mental Health, *Mental Health Medications*, 2016. Accessed at http://www.nimh.nih.gov/health/topics/mental-health-medications/index.shtml on March 31, 2016.
[6] ACF, *Managing Psychotropic Medications for Children and Youth in Foster Care*, 2012. Accessed at http://www.acf.hhs.gov/blog/2012/08/managing-psychotropic-medications-for-children-and-youth-in-foster-care on April 1, 2016.
[7] Ibid.
[8] American Academy of Pediatrics (AAP), "Health Care Issues for Children and Adolescents in Foster Care and Kinship Care," *Pediatrics*, Vol. 136, No. 4, 2015. Accessed at http://pediatrics.aappublications.org/content/136/4/e1142 on October 26, 2017.
[9] Michael Naylor, et al, "Psychotropic Medication Management for Youth in State Care: Consent, Oversight, and Policy Considerations," *Child Welfare*, Vol. 86, No. 5, 2007, pp. 175-192.
[10] AAP, *Fostering Health: Health Care for Children and Adolescents in Foster Care 2nd Edition*, 2005. Accessed at https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Fostering-Health.aspx on September 15, 2017.
[11] Ibid.
[12] ACF, Information Memorandum ACYF-CB-IM-12-03, 2012. Accessed at https://www.acf.hhs.gov/sites/default/files/cb/im1203.pdf on August 24, 2017.
[13] Michael Naylor, et al, "Psychotropic Medication Management for Youth in State Care: Consent, Oversight, and Policy Considerations," *Child Welfare* Vol. 86, No. 5, 2007, pp. 175-192.
[14] AACAP, "Practice Parameter on the Use of Psychotropic Medication in Children and Adolescents," *J. Am. Acad. Child Adolesc. Psychiatry*, Vol. 48, No. 9, 2009, pp. 961-973. Accessed at http://www.jaacap.com/article/S0890-8567(09)60156-8/pdf on March 9, 2016.
[15] Ibid.
[16] OIG, *Second-Generation Antipsychotic Drug Use Among Medicaid-Enrolled Children: Quality-of-Care Concerns* (OEI-07-12-00320), March 2015. Accessed at https://oig.hhs.gov/oei/reports/oei-07-12-00320.pdf on October 31, 2017.
[17] In all States, nearly all children in foster care are eligible for Medicaid services. According to section 1902(a)(10)(A)(i)(I) of the Social Security Act (the Act), children in foster care who are eligible for assistance payments through Title IV-E of the Act are mandatorily eligible for Medicaid. Children in foster care who are not eligible under Title IV-E usually qualify for Medicaid through other eligibility categories established by each State. Because most children in foster care are eligible for Medicaid, Medicaid pays for healthcare services for almost all children in foster care.
[18] These expenditures only reflect fee-for-service (FFS) Medicaid payments reflected in Medicaid Statistical Information System (MSIS) data for fiscal year (FY) 2013. This was the most recent complete data available at the time of State selection.
[19] The Act, § 422(b)(15)(A)(1)(v).
[20] Each State is required to submit its health services oversight and coordination plan as part of its CFSP to ACF every 5 years (45 CFR § 1357.15). The most recent plans available during the period of our review cover FYs 2015 through 2019.
[21] ACF, Program Instruction ACYF-CB-PI-12-05, 2012. Accessed at http://www.acf.hhs.gov/sites/default/files/cb/pi1205.pdf on July 30, 2015.
[22] Ibid.
[23] Ibid.
[24] Michael Naylor, et al, "Psychotropic Medication Management for Youth in State Care: Consent, Oversight, and Policy Considerations," *Child Welfare* Vol. 86, No. 5, 2007, pp. 175-192.
[25] Ibid.

[26] The compliance reviews assess State compliance with Federal requirements and the outcomes of the child welfare system. These reviews do not specifically determine whether children in foster care received treatment consistent with States' requirements. ACF, *Child and Family Service Reviews Fact Sheet.* Accessed at https://www.acf.hhs.gov/sites/default/files/cb/cfsr_general_factsheet.pdf on September 15, 2017.
[27] "Substantial conformity" is determined by the State agency's ability to meet various standards and criteria, including its capacity to deliver services leading to improved outcomes for children and families. 45 CFR § 1355.34.
[28] 45 CFR § 1355.34.
[29] 45 CFR § 1355.35(a).
[30] If the State fails to successfully complete a program improvement plan, ACF has the authority to withhold a certain amount of Federal funding for the year under review and each subsequent year until the State either successfully completes a program improvement plan or is found to be operating in substantial conformity. 45 CFR § 1355.33 – 1355.36.
[31] ACF, *CFSR Round 3 Onsite Review Instrument and Instructions*, 2016. Accessed at https://www.acf.hhs.gov/sites/default/files/cb/cfsr_r3_osri.pdf on November 14, 2017.
[32] ACF, Information Memorandum ACYF-CB-IM-12-03, 2012. Accessed at https://www.acf.hhs.gov/sites/default/files/cb/im1203.pdf on August 24, 2017.
[33] The recommendations described in this evaluation are not an exhaustive list of all professional recommendations. We have selected recommendations that are relevant to the scope of this study.
[34] AACAP, *A Guide for Community Child Serving Agencies on Psychotropic Medications for Children and Adolescents*, 2012. Accessed at http://www.aacap.org/app_themes/aacap/docs/press/guide_for_community_child_serving_agencies_on_psychotropic_medications_for_children_and_adolescents_2012.pdf on October 30, 2017.
[35] Ibid.
[36] AACAP, "Practice Parameter on the Use of Psychotropic Medication in Children and Adolescents," *J. Am. Acad. Child Adolesc. Psychiatry*, Vol. 48, No. 9, 2009, pp. 961-973.
[37] Ibid.
[38] We used eligibility and prescription drug files from the MSIS to calculate the total children enrolled in foster care in each State, and the total children who had at least one Medicaid-paid claim for a psychotropic medication in FY 2013. We used FY 2012 data for Idaho and Rhode Island because complete FY 2013 files were not available.
[39] ACF, Program Instruction (ACYF-CB-PI-12-05), April 11, 2012, p. 13. Accessed at http://www.acf.hhs.gov/sites/default/files/cb/pi1205.pdf on July 30, 2015.
[40] States are not mandated to establish requirements consistent with AACAP guidance. Therefore, our analysis does not conclude that States are in error, or have failed to meet requirements, where their requirements are not consistent with AACAP guidance.
[41] Children may receive healthcare from sources such as schools, free health clinics, or a parent's private insurance. Additionally, some of the Medicaid claims data provided for our review included Medicaid Managed Care capitated payments, which did not consistently provide detail regarding the services received by those children.
[42] GAO, HHS Guidance Could Help States Improve Oversight of Psychotropic Prescriptions (GAO-12-270T), 2011. Accessed at http://www.gao.gov/new.items/d12270t.pdf on October 31, 2017.
[43] ACF, *Program Instruction* (ACYF-CB-PI-12-05), April 11, 2012, p. 13. Accessed at http://www.acf.hhs.gov/sites/default/files/cb/pi1205.pdf on July 30, 2015.
[44] We define evaluation and management services as office visits, hospital visits, and consultations provided by qualified healthcare professionals authorized to perform such services within the scope of their practice.
[45] States are required to develop a case plan for each child in foster care. The case plan must include information such as the child's health records, medical problems, and medications. The Act, § 422(a)(8)(A)(ii), § 475(5), and § 475(1)(C).
[46] The figures for the population of children in foster care in each State represent the total unique children that were eligible for Medicaid because of their foster care status at any point during FY 2013.
[47] We considered any child who had at least one Medicaid-paid claim for a psychotropic medication while in foster care to have been treated with psychotropic medications.
[48] Medicaid managed care is a type of healthcare delivery system that provides Medicaid health benefits and services to enrollees through contracted arrangements between State Medicaid agencies and MCOs. MCOs receive a set payment per member per month from the State Medicaid agency for these services. FFS is a type of healthcare delivery system in which healthcare providers are paid for each service provided to Medicaid enrollees.

Kirsten Koch

From: Susan McKeown <swmckeown48@yahoo.com>
Sent: Saturday, April 10, 2021 9:59 PM
To: Kirsten Koch
Subject: SB 120

Follow Up Flag: Follow up
Flag Status: Completed

I spent my 41 year career as a pediatric nurse practitioner. My practice included foster children. Sadly, they are not always in the most protected situations and are frequently receiving prescribed medication. NH was the 49th state to implement the PMP. This safety measure certainly should be implemented to safeguard some of our most vulnerable children. Thank you for supporting SB 120.

Susan McKeown APRN, CPS, MFA
Author/Speaker on marriage and healthy relationships:
Beyondthefirstdance.com
F.A.S.T.E.R. Facilitator -Manchester
Tel: 603-668-4859 Cell: 603-860-9809

Voting Sheets

Senate Health and Human Services Committee

EXECUTIVE SESSION RECORD

2021-2022 Session

Bill # HB 120

Hearing Date: 4/14/21

Executive Session Date: 4/21/21

Motion: Amendment 1160s with changes **Vote:** 5-0

Committee Member	Present	Made by	Second	Yes	No
Sen. Bradley, Chair	X			X	
Sen. Gray, Vice Chair	X			X	
Sen. Avard	X			X	
Sen. Sherman	X	X		X	
Sen. Whitley	X		X	X	

Motion: OTPA **Vote:** 5-0

Committee Member	Present	Made by	Second	Yes	No
Sen. Bradley, Chair	X			X	
Sen. Gray, Vice Chair	X			X	
Sen. Avard	X			X	
Sen. Sherman	X	X		X	
Sen. Whitley	X		X	X	

Motion: Consent Calendar **Vote:** 5-0

Committee Member	Present	Made by	Second	Yes	No
Sen. Bradley, Chair	X			X	
Sen. Gray, Vice Chair	X	X		X	
Sen. Avard	X			X	
Sen. Sherman	X		X	X	
Sen. Whitley	X			X	

Motion: **Vote:**

Committee Member	Present	Made by	Second	Yes	No
Sen. Bradley, Chair					
Sen. Gray, Vice Chair					
Sen. Avard					
Sen. Sherman					
Sen. Whitley					

Reported out by: Sen. Sherman

Notes: Changes delete language "without a clinical diagnosis"

Committee Report

STATE OF NEW HAMPSHIRE

SENATE

REPORT OF THE COMMITTEE
FOR THE CONSENT CALENDAR

Thursday, April 22, 2021

THE COMMITTEE ON Health and Human Services

to which was referred **HB 120**

AN ACT relative to administration of psychotropic medications to children in foster care.

Having considered the same, the committee recommends that the Bill

OUGHT TO PASS WITH AMENDMENT

BY A VOTE OF: 5-0

AMENDMENT # 1179s

Senator Tom Sherman
For the Committee

This bill requires the department of health and human services to provide medication monitoring for children in foster care and to ensure that the use of medication restraint conforms with the limitations of RSA 126-U. This bill protects children in foster care by requiring medication monitoring whenever a medication restraint is utilized. This bill, as amended, aligns the definition of medication restraint with the definition in RSA 126-U. Other changes to the bill include cleaning up language and organization. Additionally, as amended, this bill removes certain reporting requirements at the request of the department.

Kirsten Koch 271-3266

FOR THE CONSENT CALENDAR

HEALTH AND HUMAN SERVICES

HB 120, relative to administration of psychotropic medications to children in foster care.
Ought to Pass with Amendment, Vote 5-0.
Senator Tom Sherman for the committee.

This bill requires the department of health and human services to provide medication monitoring for children in foster care and to ensure that the use of medication restraint conforms with the limitations of RSA 126-U. This bill protects children in foster care by requiring medication monitoring whenever a medication restraint is utilized. This bill, as amended, aligns the definition of medication restraint with the definition in RSA 126-U. Other changes to the bill include cleaning up language and organization. Additionally, as amended, this bill removes certain reporting requirements at the request of the department.

General Court of New Hampshire - Bill Status System

Docket of HB120

Docket Abbreviations

Bill Title: relative to administration of psychotropic medications to children in foster care.

Official Docket of **HB120.**:

Date	Body	Description
1/4/2021	H	**Introduced** (in recess of) 01/06/2021 and referred to Children and Family Law **HJ 2** P. 36
3/4/2021	H	Public Hearing: 03/04/2021 10:45 am Members of the public may attend using the following link: To join the webinar: https://www.zoom.us/j/94672611666 / Executive session on pending legislation may be held throughout the day (time permitting) from the time the committee is initially convened.
3/11/2021	H	Executive Session: 03/11/2021 09:30 am Members of the public may attend using the following link: To join the webinar: https://www.zoom.us/j/91927749754
3/15/2021	H	Committee Report: Ought to Pass with Amendment **#2021-0517h** (Vote 15-0; CC) **HC 18** P. 3
4/7/2021	H	Amendment **#2021-0517h**: AA VV 04/07/2021 **HJ 5** P. 2
4/7/2021	H	**Ought to Pass with Amendment** 2021-0517h: MA VV 04/07/2021 **HJ 5** P. 2
4/7/2021	H	Reconsider (Rep. Osborne): MF VV 04/07/2021 **HJ 5** P. 50
4/7/2021	S	Introduced 04/01/2021 and Referred to Health and Human Services; **SJ 11**
4/8/2021	S	Remote **Hearing:** 04/14/2021, 09:30 am; Links to join the hearing can be found in the Senate Calendar; **SC 19**
4/22/2021	S	Committee Report: Ought to Pass with Amendment **#2021-1179s,** 04/29/2021; Vote 5-0; CC; **SC 21**
4/29/2021	S	Committee Amendment **#2021-1179s, RC** 24Y-0N, AA; 04/29/2021; **SJ 13**
4/29/2021	S	**Ought to Pass with Amendment** 2021-1179s, **RC** 24Y-0N, MA; OT3rdg; 04/29/2021; **SJ 13**
6/10/2021	H	House Concurs with Senate Amendment 2021-1179h (Rep. Rice): MA DV 204-154 06/10/2021 **HJ 10** P. 1
7/15/2021	S	Enrolled Bill Amendment **#2021-2064e** Adopted, VV, (In recess of 06/24/2021); **SJ 20**
7/15/2021	H	Enrolled Bill Amendment **#2021-2064e**ba: AA VV (in recess of) 06/24/2021 **HJ 11**
7/21/2021	S	Enrolled Adopted, VV, (In recess 06/24/2021); **SJ 20**
7/23/2021	H	Enrolled (in recess of) 06/24/2021
8/16/2021	H	Signed by Governor Sununu 08/10/2021; Chapter 182; I. Sec. 12 Eff: 01/01/2023 II. Rem. Eff: 01/01/2022

NH House NH Senate

Other Referrals

July 8, 2021
2021-2064-EBA
08/04

Enrolled Bill Amendment to HB 120

The Committee on Enrolled Bills to which was referred HB 120

AN ACT relative to administration of psychotropic medications to children in foster care.

Having considered the same, report the same with the following amendment, and the recommendation that the bill as amended ought to pass.

FOR THE COMMITTEE

Explanation to Enrolled Bill Amendment to HB 120

This enrolled bill amendment renumbers an RSA section to avoid a conflict.

Enrolled Bill Amendment to HB 120

Amend section 12 of the bill by replacing lines 2-3 with the following:

inserting after section 4-h the following new section:

170-G:4-i Assessment for the Use of Psychotropic Medications. For children in out-of-home care

Senate Inventory Checklist for Archives

Bill Number: HB 120 **Senate Committee:** HHS

Please include all documents in the order listed below and indicate the documents which have been included with an "X" beside

X Final docket found on Bill Status

Bill Hearing Documents: {Legislative Aides}

X Bill version as it came to the committee
X All Calendar Notices
X Hearing Sign-up sheet(s)
X Prepared testimony, presentations, & other submissions handed in at the public hearing
X Hearing Report
____ Revised/Amended Fiscal Notes provided by the Senate Clerk's Office

Committee Action Documents: {Legislative Aides}

All amendments considered in committee (including those not adopted):

____ - amendment # _______ X - amendment # 2021-1179s
____ - amendment # _______ X - amendment # 2021-1166s Bradley

X Executive Session Sheet
X Committee Report

Floor Action Documents: {Clerk's Office}

All floor amendments considered by the body during session (only if they are offered to the senate):

____ - amendment # _______ ____ - amendment # _______
____ - amendment # _______ ____ - amendment # _______

Post Floor Action: (if applicable) {Clerk's Office}

____ Committee of Conference Report (if signed off by all members. Include any new language proposed by the committee of conference):
X Enrolled Bill Amendment(s) 2004
____ Governor's Veto Message

All available versions of the bill: {Clerk's Office}

X as amended by the senate ____ as amended by the house
X final version

Completed Committee Report File Delivered to the Senate Clerk's Office By:

Kirsten Koch 7/26/21
Committee Aide **Date**

Senate Clerk's Office _______