**Misdiagnosis and Inappropriate Medication of Foster Children**

* The symptoms of trauma overlap with the symptoms of several mental health disorders. Both the **American Academy of Child and Adolescent Psychiatry and the American Academy of Pediatrics agree that a real risk of misdiagnosis of mental disorders occurs when a child is actually suffering from trauma instead**.
* **Misdiagnosis leads to inappropriate treatment, including inappropriate use of psychotropic medication** for foster children, so the children are receiving treatment that is wrong for them, makes them worse, and has harmful side effects.
* **Texas statistics confirm the risk of misdiagnosis and the overuse of psychotropic medication** with our foster children.
	+ According to the report of the DFPS Medical Director in a hearing for the Texas House Human Services Committee in 2018, 54% of children in the foster care system have a behavioral health diagnosis. According to the CDC, among children living below the poverty line, 22% had a mental, behavioral, or developmental disorder diagnosis. This number aligns with the National Institute of Health, which states that approximately 20% of Americans live with a mental illness. This means that children in the foster care system are nearly 3 times more likely to be diagnosed with a mental/behavioral health disorder than other at-risk children in the general population.
	+ According to HHSC and DFPS, 49.45% of 13-17 year old children in foster care were prescribed a psychotropic medication, and one-third of 6-12 year old children in foster care were prescribed psychotropic medication in 2017. 60% of the children who were prescribed a psychotropic medication were under the age of 13.
	+ The difference in use of psychotropic medication for children in foster care is most clear when compared with other children in Texas who are also receiving Medicaid benefits. 14% of 6-12 year old children who are on Medicaid but not in foster care were prescribed psychotropic medication in 2018. That is to be compared with 34% of 6-12 year old children in foster care who were prescribed psychotropic medication. Similarly, 17% of 13-17 year old children who are on Medicaid but not in foster care were prescribed psychotropic medication in 2018. On the other hand, 48% of 13-17 year old children in foster care were prescribed psychotropic medication.
	+ Therefore, a **child in foster care is 3x more likely to be diagnosed with a mental illness or prescribed a psychotropic medication than other children**, even other children in what we may consider at-risk conditions.
* In 2017, the **State of Texas spent $31,266,810 on psychotropic medications** for children in our foster care system.
* Three key mental health experts recently discussed these issues:
* **Eugene Griffin** is a clinical psychologist who trained at Harvard University Medical School and is the Senior Fellow for Policy and Practice at the ChildTrauma Academy in Houston. According to Dr. Griffin:
	+ **Symptoms of trauma overlap with symptoms of several mental health disorders**. The American Academy of Child and Adolescent Psychiatry (2010) lists symptoms of trauma that are shared by eight mental health diagnoses, including bipolar disorder; attention deficit / hyperactivity disorder; oppositional defiant disorder; panic disorder; anxiety disorder; major depressive disorder; substance abuse disorder; and psychotic disorder.
	+ Diagnosis often drives treatment. Best practices for many of the mental health diagnoses … include the consideration of different psychotropic medications. **Best practice for child trauma does not put a primary focus on psychotropic medications**.
	+ **If a traumatized child is misdiagnosed with a mental illness that child can be at risk for being prescribed inappropriate psychotropic medications**.
	+ The **potential for misdiagnosis is present for many children**, particularly older children. In a study we conducted (2012) at Northwestern University Medical School, looking at the intake clinical assessment for over 14,000 children taken into the custody of Illinois child welfare, we found that 13% of 0-6 year olds; 39% of 7-12 year olds; 54% of 13 - 16 year olds; and 62% of youth 17 or older had symptoms that overlapped with trauma and mental health diagnoses. These are youth at high risk for misdiagnosis and inappropriate medications.
	+ The **study recommended that** child welfare agencies adopt policies requiring that mental health screenings and assessments of all youth include measures of traumatic events and trauma-related symptoms; and that **a clinician not diagnose a youth in child welfare with a mental illness without first addressing the impact of trauma**. Implementing such recommendations would require training the clinicians.
	+ In a joint guidance letter from ACF, SAMHSA, and CMS (2013) to state child welfare directors the federal administrators recognized that the high rates of trauma for children in child welfare "have far-reaching consequences," including that these children "are far more likely than their peers to receive psychotropic medications, including atypical antipsychotic medications." The administrators added "[t]here is reason to believe that such widespread and at times problematic use of these drugs is a reaction to the clinical complexity of symptoms among children exposed to complex trauma."
* In order to reduce the misdiagnosis of children in the public sector and the subsequent inappropriate use of psychotropic medication, medical and mental health professionals must be trained to understand child trauma.

* Providing trauma training for the medical and mental health professionals who are diagnosing, prescribing psychotropic medication for, or treating medical and behavioral health conditions under the Texas STAR Health program, should improve the quality of care to children in this program and result in their improved well-being.
* **Bruce D. Perry, M.D., Ph.D.**, who is a child psychiatrist and neuroscientist, is the founder of the ChildTrauma Academy in Houston and is **one of the most highly acclaimed experts on child trauma in the world**. Dr. Perry spoke about these very issues at a presentation in Dallas just this past November. There, he said, speaking about children with trauma-related mental health symptoms --
	+ **So what we are doing right now in mental health with kids that are in foster care, who have had incredibly complex developmental histories … we put them into 1 of 5 boxes (diagnostic boxes)**. And every one of these kids that ends up in one of these boxes, well let’s give them a medication, and so **we end up giving them medications, and that doesn’t work, so we add a medication, then we add another medication**, and we add another medication.
	+ I am fortunate to be part of a large network across the world, and we created this network so we could get adequate numbers of children who have been similarly evaluated, so we could actually do quality research, and we now have over 50,000 kids….**And one of the things we’ve been able to do is take a lot of these kids and look at how they ended up with the same, exact same, diagnoses but they were completely different neurobiologically,** and that it’s no surprise then that because they’re very different that the “one size fits all” use of medications didn’t work.
	+ Dr. Perry then showed Spect scan images of different children’s brains and commented that although their brains are completely different, they **were all given the same diagnoses -- some combination of ADHD, Bipolar Disorder, Oppositional Defiant Disorder, & Conduct Disorder.** He then stated, **And I literally could do this, I could show you 5,000 of these.** And the biggest problem we have is that these **kids were all treated the same. They were all given more than 4 medications** for chronic periods of time. They **weren’t given the therapeutic interventions that we know help these kids, which are all relationship based.**
	+ **Relationships heal**. Relationships buffer….And the only thing that helps these kids, and we’ve got tons of data to show this, as do others…. relationships make a lot of difference.
	+ **So if you take a child who’s had these backgrounds, and you put them in an environment where there is relational consistency and nurturing and patience**, and the people who are in the child’s life – the foster parents, the adoptive parents, the schools, the therapist, understand trauma, they will interact with these kids in ways that are sensitive and healing, and **they’ll get better**.
	+ **If they don’t understand these kids, they’ll do stuff like throw their hands up and say this kid has ADHD and send him to a pediatrician, see him for 10 minutes, get a prescription and then call again when it doesn’t work**, add Risperdal, and that doesn’t work, and add an antidepressant, and that doesn’t work, and add another antipsychotic, and that doesn’t work.
	+ This **state continues to have practitioners that don’t know anything about these issues** – that write prescription after prescription after prescription.
	+ Right now as we sit here, there is some kid sitting in a doctor’s office whom he sees every 2 months for 10 minutes, and that doctor is going to say, “I’m going to up your dose of Risperdal,” and they’re writing that prescription now. And all we know about Risperdal – we know it doesn’t help these kids. What we do know is that it increases your risk for diabetes – triples it.
	+ **As the State of Texas, you are paying these people to make these kids worse**.
* Finally, **Dr. Greta Kerwin**, a clinical psychologist who conducted psychological evaluations of children under the care of DFPS in Region 3 for over a decade, stated:
	+ Trauma Informed Care, in my professional opinion, should be the standard of care. However, up to the point when I had to go on medical leave, I was the only psychologist in the region conducting developmental and psychological assessments from a Trauma Informed Care … standpoint.
	+ I have seen **a lot of misdiagnosis of children as he/she either having Bipolar Disorder and/or ADHD when rather his/her history of trauma and/or attachment style is the root of the child’s difficulties**. **Medicating children for a disorder they do not have is very dangerous** as we do not know the long-term effects of psychotropic medication on children and their developing brain. If a child has a history of trauma and subsequent attachment difficulties, environmental interventions that address the trauma and attachment style have been the most effective, not medication. I have also seen children, which always alarmed me, who had already been placed on medication before they even had their psychological evaluation and not yet had a chance to get used to being in their new living environment. **Being on medication and receiving the wrong diagnosis also puts a child at great risk of being psychiatrically hospitalized (often repeatedly) and eventually placed in a residential treatment facility**, where the child fails, because of misdiagnosis. This **sets the child up for failure throughout life because the** **real reasons for the child’s difficulties have not been addressed** before he/she ages out of the system.
	+ Letting the research speak for itself and the experts working with this population share their wisdom via required training for all involved with each child’s care will allow these children to receive the best care possible, give them a fighting chance in life, and save the state money by avoiding unnecessary foster home removals, increases in level of care, hospitalizations, placements in residential treatment centers, and the requests I received to re-evaluate a child due to concerns about misdiagnosis.