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PRESCRIBED INJUSTICE: EXAMINING STATE-SANCTIONED OVER-MEDICATION OF FOSTER YOUTH IN TEXAS

By: Hiba Loya*

* J.D. Candidate, University of Houston Law Center, 2025.

ABSTRACT

The overmedication of foster youth presents a complex and pressing issue within the realm of child welfare and mental health care. This paper offers a comprehensive examination of the landscape surrounding psychotropic medication administration to foster youth in Texas. Further, this paper also delves into the background of overmedication, elucidating the scope and intricacies of the issue. Additionally, this paper discusses the nature of psychotropic medication, the guidelines set forth by Texas, federal regulations, and challenges in diagnosing mental health disorders among foster youth, all underscored by empirical data.

The paper explores the administration of medication, detailing Texas laws and regulations governing the process, as well as the oversight mechanisms in place. This section also examines the landmark legal case *M.D. v. Abbott*, tracing its procedural history and analyzing its implications on the administration of psychotropic medication to foster youth. The aftermath of this case, including reports from monitors, is also scrutinized. Drawing from the analysis, the paper proposes recommendations aimed at mitigating the overmedication of foster youth in Texas. Suggestions include updating the state's current psychotropic medication utilization review process, advocating for a proactive approach to medication reviews, and revisiting the parameters governing medication administration for children between the ages of thirteen to seventeen.

This paper underscores the urgent need for comprehensive reform in the administration of psychotropic medication to foster youth in Texas. By addressing legal, regulatory, and procedural gaps, it seeks to safeguard the well-being and rights of some of the most vulnerable members of society.

I. INTRODUCTION

"These children have for too long been forgotten. Their stories deserved to be told."[1]

The Texas foster care system has failed children and riddled their lives with more abuse, neglect, and even death. The primary purpose of the foster care system is to provide safety and stability for children who cannot live safely at home.[2] Despite this, in 2015, Senior U.S District Justice Janis Graham Jack found that "rape, abuse, psychotropic medication, and instability are the norm" for children in Texas' custody.[3] This case revealed the atrocities plaguing Texas's foster care system and made clear that foster youth in state custody "almost uniformly leave State custody more damaged than when they entered."[4]

Of the many issues discussed in this case, a primary concern is the overmedication and inappropriate administration of psychotropic medication to minors in state custody. The Texas Family Code defines "psychotropic medication" as "medication that is prescribed for the treatment of symptoms of psychosis or another mental, emotional, or behavioral disorder."[5] This includes antidepressants, antipsychotics, agents for control of mania or depression, hypnotics, and psychomotor stimulants, amongst others.[6]

Psychotropic medication can have intense and life-altering effects on children.[7] There is no doubt that these drugs offer benefits to children with diagnosed mental health conditions when properly admin-

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[1] M.D. v. Abbott, 152 F. Supp. 3d 684, 828 (S.D. Tex. 2015).

[2] *Foster Care*, TEX. DEP'T OF FAM. & PROTECTIVE SERVS., https://www.dfps.texas.gov/Child_Protection/Foster_Care/default.asp (last visited, Sept. 23, 2023).

[3] *M.D.*, *supra* note 1*; see also* Cameron Langford, *Federal Judge Rips Texas Over Handling of Foster Youths' Psychotropic Drugs*, COURTHOUSE NEWS SERVICE (Apr. 12, 2023), https://www.courthousenews.com/federal-judge-rips-texas-over-handling-of-foster-youths-psychotropic-drugs/.

[4] *M.D.*, *supra* note 1.

[5] TEX. FAM. CODE ANN. § 266.001(7) (West 2017).

[6] *Id.*

[7] *Psychotropics*, CHILDREN'S RIGHTS, https://www.childrensrights.org/focus-areas/psychotropics#:~:text=Psychotropic%20medications%20unadvisedly%20prescribed%20or,organ%20damage%2C%20and%20suicidal%20thoughts (last visited Sept. 28, 2023).

istered.[8] However, as emphasized by the *M.D. v. Abbott* holding, proper administration and proper regulation of psychotropic medication is rare amongst children in state custody.[9]

The *M.D v. Abbott* monitoring team made fourteen multi-day site visit inspections[10] of the Texas Foster Care system between December 13, 2021, and December 31, 2022.[11] The monitoring team's investigation revealed several concerns related to psychotropic medication amongst other health and safety concerns.[12] After completing site visits, the monitoring team noted that 47% of children whose files were reviewed were prescribed four or more psychotropic medications, the youngest of these children being eight years old.[13] Further, in many situations, these medications are being used as a chemical restraint. D.P., a class representative in *M.D v. Abbott*, shares her experience of being "chemically restrained."[14] D.P. explains how she was injected with a drug "cocktail" prescribed by a physician.[15] Abhorrently, the physician "left it up to the staff to administer however many shots they wanted to."[16] This is yet another illustration of the inappropriate administration and overmedication of foster youth in the State of Texas. Although D.P is one individual, she represents many children currently in state custody that do not have a voice.

This Comment will examine the consequences of state-sponsored over medication of foster youth in Texas. Specifically, this Comment will analyze the legal process of administering psychotropic medica-

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[8] M.D. v. Abbott, 152 F. Supp. 3d 684, 828 (S.D. Tex. 2015); *see also Psychotropics*, *supra* note 7.

[9] *M.D., supra* note 8, at 828.

[10] 2023 Monitors' Report, *infra* note 165. Despite the fact that 14 multi-day and 19 awake-night visits occurred at these operations, the samples do not represent a statistically significant sample of the more than 200 facilities that house PMC children in Texas. As part of the site visits, the monitoring team did not choose operations randomly, but rather based on data available and enforcement records from HHSC and DFPS that demonstrated child safety risks, or were near other facilities being visited.

[11] *Id.* at 1.

[12] *Id.* at 3.

[13] *Id.* at 7.

[14] M.D. v. Abbott, 152 F. Supp. 3d 684, 812 (S.D. Tex. 2015).

[15] *Id.*

[16] *Id.*

tion to foster youth, how the system currently in place right now is failing, what has been done to address this issue, and propose solutions as to what can be done to remedy some of these issues.

Part I will outline the scope of the issue and expand on what psychotropic medicine is, what it is used for, and the health repercussions of taking these medications as a minor. Then, this Comment will introduce how children in state-custody receive access to psychotropic medication and an overview of the regulatory systems and formal procedure(s) involved in the process. Next, this Comment will discuss the federal regulations in place and the practice of prescribing psychotropics for "off-label" purposes. Moreover, this Comment will address difficulties diagnosing mental health disorders amongst foster youth. Part I will conclude with an analysis of research on the use of psychotropics amongst foster youth and non-foster youth.

Part II of this Comment will evaluate the legal process of administering psychotropic medication to foster youth. This section will explain the Texas laws and regulations in place regarding medical care for youth in state custody. In doing so, this Comment will analyze the State's agency oversight of psychotropic medication administered to youth in state custody.

Part III will discuss what has been done to reform the foster care system as it pertains to overmedication since the *M.D v. Abbott* holding. This part will highlight the reports from court-mandated monitors in charge of assessing and reporting on Texas' compliance with the *M.D. v. Abbott* holding. Importantly, this part will tell the story of C.G.

Part IV will discuss possible solutions to the overmedication issues plaguing foster youth in the state of Texas. Specifically, this part will discuss changes that can be made to the state's current process of agency oversight of psychotropic prescriptions for children in the Texas child welfare system.

II. THE SCOPE OF OVERMEDICATION

A. What is Psychotropic Medication?

Psychotropic medication is used to treat mental, emotional, or behavioral disorders.[17] As mentioned earlier, the Texas Family Code (TFC) defines "psychotropic medication" as "medication that is prescribed for the treatment of symptoms of psychosis or another mental, emotional, or behavioral disorder" which includes antidepressants, antipsychotics, agents for control of mania or depression, hypnotics, and psychomotor stimulants amongst others.[18] Psychotropic medications are commonly used to treat disorders such as: depression, anxiety, sleep disorders, bipolar disorder, attention deficit hyperactivity disorder (ADHD), etc.[19]

It is important to note that psychotropic medications are not a cure.[20] Instead, psychotropic medications work to manage symptoms of mental illness such as mood swings, anger, and hallucinations.[21] The idea is that the medication will allow a person to better control their symptoms and focus their energy on developing coping skills to manage their mental health.[22] It appears that these medications are a temporary fix, or at the very least, a form of treatment that must be coupled with other mental health services in order for someone to fully reap the benefits of taking psychotropics. In fact, the American Academy of Child & Adolescent Psychiatry (AACAP) states that such medication should not be used on its own and instead should be part of a comprehensive treatment plan based on a comprehensive psychiatric evaluation.[23]

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[17] *See* TEX. FAM. CODE ANN. § 266.001(7) (West 2017).

[18] *Id.*

[19] Caitlin Geng, *What to Know About Psychotropic Medications*, MEDICALNEWSTODAY (Oct. 18, 2022), https://www.medicalnewstoday.com/articles/psychotropic-medications#uses.

[20] Smitha Bhandari, *What Are Psychotropic Medications*, WEBMD (May 15, 2023), https://www.webmd.com/mental-health/what-are-psychotropic-medications.

[21] *Id.*; Kristalyn Salters-Pedneault, *Understanding Psychotropic Drugs*, VERYWELLMIND (June 10, 2023), https://www.verywellmind.com/psychotropic-drugs-425321.

[22] Salters-Pedneault, *supra* note 21.

[23] *Facts for Families: Psychiatric Medication for Children and Adolescents: Part 1—How Medications Are Used*, 21 AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 1, 1 (2017).

Moreover, studies have shown that psychotropic medication can have long-lasting and serious side effects on adults using them, but little is known about the effects of long-term use of psychotropic medication in children.[24] When prescribed and consumed correctly, psychotropic medication may reduce or even eliminate troubling symptoms thus improving the daily functioning of individuals with psychiatric disorders.[25] Depending on the type of psychotropic medication, the side effects may vary.[26] Side effects can range from minor inconveniences like constipation, restlessness, headaches, nightmares, and fatigue to more serious complications such as liver problems, convulsions, trouble breathing, hallucinations, respiratory disease, abnormal bleeding, and even suicidal thoughts.[27]

B. Texas Guidelines on the Administration of Psychotropic Medication

The Texas Department of Family Protective Services (DFPS) is a state division that works to protect children and vulnerable adults from abuse, neglect, and exploitation through investigations, services, and prevention programs.[28] Specifically, Child Protective Services (CPS) is the DFPS division tasked to protect children from abuse and neglect through various services including foster care and adoption.[29] With a goal to create guidelines to properly administer psychotropic medication, Texas became one of the first states to develop a "best practices" guide regarding the administration and

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[24] TEXAS CHILD WELFARE LAW BENCH BOOK, SUP. CT. OF TEX. PERMANENT JUD. COMM'N FOR CHILD., YOUTH, AND FAM. 247 (2023), https://texaschildrenscommission.gov/media/dfxpfdl5/2023-child-welfare-bench-book-final-online.pdf.

[25] *Facts for Families: Psychiatric Medication for Children and Adolescents: Part 1—How Medications Are Used*, *supra* note 23.

[26] Bhandari, *supra* note 20.

[27] *List of Psychotropic Medications and Side Effects*, TEX. HEALTH AND HUM. SERVS. (2023), https://www.hhs.texas.gov/sites/default/files/documents/List-of-Psychotropic-Medications-and-Side-Effects.pdf.

[28] *Learn About DFPS*, TEX. DEP'T OF FAM. AND PROTECTIVE SERVS., https://www.dfps.texas.gov/About_DFPS/default.asp (last visited Oct. 21, 2023).

[29] *Id.*

oversight of psychotropic medication to foster youth.[30] DFPS collaborated with the Department of State Health Services (DSHS) and the Health and Human Services Commission (HHSC) to create the *Psychotropic Medication Utilization Parameters for Children and Youth in Texas Public Behavioral Health, 6th Edition* (Parameters).[31] The Parameters serve as a resource for physicians administering medication to children with mental health disorders in the public behavioral health system.[32]

The Parameters outline the issues with prescribing psychotropic medication to adolescents and provides best practices to ensure that foster youth are receiving appropriate medical care that does not put them at risk.[33] Specifically, the Parameters describe trauma-informed care, informed consent, and lists what should be discussed with the prescribing doctor before consenting.[34] However, despite the State's attempt to regulate and properly administer psychotropic medication to foster youth in need, a 2022 court-ordered report found that 47% of the children at the fourteen facilities whose records were examined were prescribed *at least* four psychotropic drugs.[35] Of those, "nearly three-fourths had never or not within the past year received a clinical review" despite it being required by the Parameters.[36] These data points illustrate the dire need for reform and a new approach to regu-

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[30] SUP. CT. OF TEX. PERMANENT JUD. COMM'N FOR CHILD., YOUTH, AND FAM., *supra* note 24, at 247.

[31] *Id.*

[32] *Id.*

[33] PSYCHOTROPIC MEDICATION UTILIZATION PARAMETERS FOR CHILDREN AND YOUTH IN TEXAS PUBLIC BEHAVIORAL HEALTH (Tex. Health and Hum. Servs. ed., 2019), https://www.hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/facilities-regulation/psychiatric/psychotropic-medication-utilization-parameters.pdf [hereinafter PARAMETERS].

[34] SUP. CT. OF TEX. PERMANENT JUD. COMM'N FOR CHILD., YOUTH, AND FAM, *supra* note 24, at 249.

[35] Robert T. Garret, *Judge: Texas Doesn't Shield Foster Kids From Sexual Abuse, Overuses Mental-Health Drugs*, DALLAS MORNING NEWS (Apr. 12, 2023), https://www.dallasnews.com/news/politics/2023/04/12/judge-texas-doesnt-shield-foster-kids-from-sexual-abuse-overuses-mental-health-drugs/; *See also* PARAMETERS, *supra* note 33, at 10.

[36] *See* Garret, *supra* note 35; *see also* PARAMETERS, *supra* note 33, at 10.

lation and enforcement of regulation in the administration of psychotropic medication to foster youth.

C. Federal Regulation and Off-Label Medication

Federal approval and oversight of psychotropic medication amongst children also plays a role. The Food and Drug Administration (FDA) is the government agency responsible for approving new medications.[37] After conducting research and experiments, if the FDA believes the benefits of a certain medication outweigh its known risks, then the medication is approved and can be marketed in the United States.[38] Due to statutory mandates, the FDA ensures that product labeling accurately reflects the pharmaceutical company's research on safety and efficacy for the indications listed.[39]

Regarding psychotropics, it is well-established that many psychotropic medications do not have FDA approved labeling for use in children.[40] Psychotropics lack FDA approved labeling for use in children because the medication being approved by the FDA is based on research on adults, not children.[41] On their website, the FDA clearly states that "[m]ost drugs prescribed for children have not been tested in children."[42] The webpage, titled *Drug Research and Children*, contains warnings from numerous experts about the dangers of using data from adults and adjusting the dose according to a child's weight.[43] The experts continue to explain that doctors have experimented over the years to determine which medication is best for children; however, "this trial-and-error approach has also resulted in

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[37] U.S. FOOD AND DRUG ADMINISTRATION, https://www.fda.gov/drugs (last visited Oct. 21, 2023).

[38] Kimber E. Strawbridge, *The Children Are Crying: The Need for Change in Florida's Management of Psychotropic Medication to Foster Children*, 15 U.C. DAVIS J. JUV. L. & POL'Y 247 (2011).

[39] PARAMETERS, *supra* note 33, at 5.

[40] PARAMETERS, *supra* note 33, at 5.

[41] PARAMETERS, *supra* note 33, at 5.

[42] *Drug Research and Children*, U.S. FOOD & DRUG ADMIN., https://public4.pagefreezer.com/content/FDA/01-04-2024T10:11/https://www.fda.gov/drugs/information-consumers-drugs/drug-research-and-children (last visited Jan. 16, 2024).

[43] *Id.*

tragedy."[44] Additionally, the FDA does *not* regulate how approved medication is administered.[45] The FDA does not regulate health provider practices and has even explicitly stated that it does "not limit the way a practitioner may prescribe an approved drug."[46]

Despite the lack of FDA oversight regarding the administration of medication, clinicians often support the use of medication for an "off-label" use.[47] An "off-label" prescription allows for the prescription of higher dosages or medication not approved for children.[48] Off-label means the medication "has not undergone scrupulous scientific testing in children[;]" therefore, researchers are not sure how these medications affect a child's growing body.[49] Prescribing off-label medication as a regular practice is especially relevant in child psychiatry due to the lack of FDA-registration trials involving adolescents.[50]

The lack of scientific data on the safety and efficacy of psychotropic medication amongst adolescence is largely attributable to the ethical concerns surrounding such testing.[51] Experts in the field have concerns about a child's ability to comprehend and consent to a scientific study that would require the child to consume psychotropic medication with unknown side effects for experimental purposes.[52] Ultimately, clinicians and physicians treating foster youth are allowed to prescribe psychotropic medication for purposes not listed on the label, with unknown side effects and unknown developmental risks to children in state custody, even though off-label use may not be safe or effective.[53] Even the Parameters include "[l]iterature based maximum doses" for medications where there is support for "off-

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[44] *Id.*

[45] PARAMETERS, *supra* note 33, at 5.

[46] PARAMETERS, *supra* note 33, at 5.

[47] PARAMETERS, *supra* note 33, at 5.

[48] Matthew M. Cummings, *Sedating Forgotten Children: How Unnecessary Psychotropic Medication Endangers Foster Children's Rights and Health*, 32 B.C.J.L. & SOC. JUST. 357, 360 (2012).

[49] Strawbridge, *supra* note 38, at 250.

[50] PARAMETERS, *supra* note 33, at 5.

[51] Strawbridge, *supra* note 38, at 250.

[52] *Id.*

[53] *Id.*

label" use and states that "studies and expert clinical experience often *support* the use of a medication for an 'off-label' use."[54]

D. Difficulties Diagnosing Mental Health Disorders amongst Foster Youth

At present, there are no biomarkers to assist with the diagnosis of medical disorders and other tests generally are not helpful in making a clinical diagnosis of a mental health disorder.[55] Further, foster youth as a population have "multiple complex care needs relating to rapid developmental changes, incomplete brain maturation, diagnostic uncertainty, incomplete long-term evidence base for most medication classes, impact of ecological systems such as family and school, and issues of self-determination."[56] Due to the numerous difficulties addressing mental health diagnoses in children, the best practice established is to prescribe psychotherapy or undertake environmental changes before proceeding with pharmacotherapy.[57] Training required for medical consenters plainly states that "[t]he vast majority of children in DFPS conservatorship do not need psychotropic medications."[58] Because of the risky side effects, the lack of research on the developmental risks psychotropics have on adolescents, the minimal FDA regulation and approval for use in children, and the overall mind-altering impact, best practices require that "children should only take psychotropic medication when absolutely necessary and as a last resort."[59]

E. What does the data say?

A study from May 2023 compared the prevalence of psychotropic medication dispensing among foster youth with those among

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[54] PARAMETERS, *supra* note 33, at 5.

[55] PARAMETERS, *supra* note 33, at 4.

[56] PARAMETERS, *supra* note 33, at 3.

[57] PARAMETERS, *supra* note 33, at 4.

[58] *Psychotropic Medication for Children in Texas Foster Care*, TEX. DEP'T OF HEALTH AND HUM. SERVS. (Nov. 2013), https://www.dfps.texas.gov/Training/Psychotropic_Medication/docs/Psychotropic_Medication_Training.pptx.

[59] Cummings, *supra* note 48, at 361.

non-foster youth on Medicaid.[60] The study showed that children in foster care had 6.8 times higher odds of being prescribed psychotropic medication than their non-foster peers (after controlling for age group, gender, and a number of mental and developmental diagnoses).[61] The report establishes that while "psychotropic polypharmacy", or the use of multiple medications at the same time, is common in foster youth, there is limited data to support its safety and efficacy.[62] **Exhibit A** illustrates the percentages at which children (by their age group) are taking psychotropic medication.[63] A quick glance at the bar graph will show the significant increase in psychotropic medication consumption amongst foster youth.[64] Ultimately, the study revealed that children in foster care were disproportionately more likely to be dispensed psychotropic medication than their non-foster peers. [65] Further, foster youth were more likely to consume psychotropic medication absent a mental health or developmental disability diagnosis.[66]

Another study on the use of psychotropics amongst foster youth in treatment foster care reported that of the youth taking psychotropic medication, 61% took two or more and yet, *only 22%* actually met the criteria for psychotropic polypharmacy.[67] Thus, not only are foster youth being prescribed psychotropic medication with limited efficacy data at a significantly higher rate than their peers, but many foster youth who do not satisfy the criteria for polypharmacy are

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[60] Rachael Keefe et al., *Psychotropic Medication Prescribing: Youth in Foster Care Compared with Other Medicaid Enrollees*, 33 J. OF CHILD AND ADOLESCENT PSYCHOPHARMACOLOGY 149, 149–55 (2023), http://doi.org/10.1089/cap.2022.0092 [hereinafter *Youth in Foster Care Compared with Other Medicaid Enrollees*].

[61] *Id.*

[62] Rachael Keefe, *The Psychotropic Medication Usage Among Foster and Non-Foster Youth on Medicaid*, AM. ACAD. OF PEDIATRICS (Oct. 7, 2021), https://www.aap.org/en/news-room/news-releases/aap/2021/children-in-foster-care-much-more-likely-to-be-prescribed-psychotropic-medications-compared-with-non-foster-children-in-medicaid-program/.

[63] *Id.*

[64] *Id.*

[65] *Youth in Foster Care Compared with Other Medicaid Enrollees*, *supra* note 60.

[66] *Youth in Foster Care Compared with Other Medicaid Enrollees*, *supra* note 60.

[67] Sharon Brenner et al., *Use of Psychotropic Medications Among Youth in Treatment Foster Care*, 23 J. CHILD FAM. STUD. 666, 666–74 (2013), https://doi.org/10.1007/s10826-013-9882-3.

nonetheless prescribed two or more psychotropic medications at a time.[68] Additionally, if a child reacts adversely to taking two or more concomitant psychotropics, it may be difficult for a physician to differentiate between new behavioral symptoms which can lead to even more medication prescriptions.[69]

This study underscores the absence of clear data supporting the safety and efficacy of medications in children.[70] The authors specifically express concern about medication when it is prescribed "off-label."[71] As discussed earlier, due to the lack of FDA regulation of psychotropic medication use amongst children, physicians may prescribe medication not approved for or tested on children.[72] Due to the lack of testing in children, researchers are unsure of the effects of psychotropics on a child's growing body.[73] It follows that the authors of the study question whether the elevated rates of psychotropic medication use amongst foster youth is clinically warranted or even therapeutically beneficial.[74]

Overall, psychotropic medication is often prescribed to youth in state custody at alarming rates. The side effects of psychotropic medications vary in severity and there is little efficacy data supporting the use of psychotropic medication amongst youth, making it a questionable choice of treatment for children.[75] Texas has created the Parameters to guide clinicians who diagnose foster youth; however, it is unclear whether these best practices are being applied.[76] Moreover,

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[68] Brenner et al., *supra* note 67.

[69] Julie Zito et al., *Psychotropic Polypharmacy in the US Pediatric Population: A Methodologic Critique and Commentary*, 12 CHILD & ADOLESCENT PSYCHIATRY 1, 10 (2021) ("These findings raise questions about the long-term effectiveness and safety of off-label combinations as well as the relationship of multiple comorbidities to overprescribing. At the core of pediatric psychotropic prescribing lies a deeper question about the U.S. standard of medical care for the off-label treatment of behavioral problems of children and adolescents, a topic beyond the scope of this review").

[70] Brenner et al., *supra* note 67.

[71] *Id.*

[72] PARAMETERS, *supra* note 33, at 5.

[73] Strawbridge, *supra* note 38.

[74] Brenner et al., *supra* note 67.

[75] Brenner et al., *supra* note 67.

[76] *See* Garret, *supra* note 35; *see also* 2023 Monitors' Report, *infra* note 165, at 4–5.

the practice of prescribing medication for *off-label* use poses unknown risks to an already vulnerable population.[77] Finally, recent studies reveal the astonishing rates at which foster youth are more likely to be prescribed psychotropics (often more than one) at increasingly higher rates. The lack of federal regulation in prescribing psychotropic medication coupled with the difficulties diagnosing foster youth with mental health disorders necessitates extreme caution and the stringent enforcement of all applicable regulatory procedures.

III. ADMINISTRATION OF MEDICATION

A. Texas Law and Regulations

As established, foster youth are significantly more likely to be prescribed psychotropics. This begs the question: what is the regulatory scheme through which foster youth are prescribed psychotropics? The answer lies in Chapter 266 of the TFC which states the applicable laws regarding medical care for children in DFPS conservatorship.[78] DFPS conservatorship means the child is in the legal custody of the State of Texas and DFPS.[79] Once a child is in state custody, the court may authorize an individual designated by name in a court order to consent to medical care for the child.[80] The court-designated medical consenter can be the child's foster parent or even the child's natural parent, if the parent's rights have not been terminated and the court determines that it is in the best interest of the child to allow the parent to consent to medical care.[81] Alternatively, the court may designate DFPS as the medical consenter.[82] DFPS may choose to designate the child's foster parent, or the child's natural

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[77] Sumit Bhagra, *Taking Off-Label Medication*, MAYO CLINIC HEALTH SYS., https://www.mayoclinichealthsystem.org/hometown-health/speaking-of-health/taking-off-label-medication (last visited Nov. 8, 2023).

[78] TEX. FAM. CODE ANN. § 266 (West 2017).

[79] *Psychotropic Medications*, TEX. DEPT. OF FAM. AND PROTECTIVE SERVS., https://www.dfps.texas.gov/Training/Psychotropic_Medication/default.asp (last visited Nov 8, 2023).

[80] TEX. FAM. CODE ANN. § 266.004(b) (West 2017).

[81] *Id.*

[82] *Id.*

parent to be responsible for consenting on behalf of DFPS.[83] When given the authority to consent to medical care for a child in state custody, DFPS designates up to four primary and backup medical consenters.[84] The two primary medical consenters are usually the child's caregivers or a caseworker and another CPS staff.[85]

The appointed medical consenter is required to complete a department-approved training program related to informed consent.[86] The training must discuss informed consent for the administration of psychotropic medication and the appropriate use of psychosocial therapies, behavior strategies and other non-pharmacological interventions that should be considered before or concurrently with the administration of psychotropic medications.[87] This training explicitly states that "most children in DFPS conservatorship never need psychotropic medications[,]" and emphasizes that children who are traumatized might show negative behaviors that are a normal reaction to what they have been through.[88] Once the training is complete, the medical consenter must acknowledge in writing that they have received the training, understand the principles of informed consent for the administration of psychotropic medication, and understand that non-pharmacological interventions should be considered before consent to the use of psychotropic medication.[89] Lastly, the medical consenter is required to participate at the child's doctor's appointments.[90]

If the court determines that a child has the capacity to consent to medical care, then a child–who is at least sixteen years old–may con-

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[83] TEX. FAM. CODE ANN. §266.004(c) (West 2017).

[84] SUP. CT. OF TEX. PERMANENT JUD. COMM'N FOR CHILD., YOUTH, AND FAM., *supra* note 24, at 235.

[85] *Id.*

[86] TEX. FAM. CODE ANN. § 266.004(h) (West 2017).

[87] *Id.*

[88] *Psychotropic Medication Training*, TEX. DEPT. OF FAM. AND PROTECTIVE SERVS, https://www.dfps.texas.gov/Training/Psychotropic_Medication/docs/Psychotropic_Medication_Training.pptx (last visited Nov 8, 2023).

[89] TEX. FAM. CODE ANN. § 266.004(h-2) (West 2017).

[90] TEX. FAM. CODE ANN. § 266.004(i) (West 2017).

sent to the provision of their own medical care.[91] Attorneys *ad litem* (court-appointed legal guardians) and DFPS coordinators are required to inform sixteen-year-olds in foster care of their right to ask the court whether they can consent to their own medical care.[92] In the situation that a child is refusing medical care, DFPS can file a motion with the court requesting an order authorizing the provision of medical care.[93] An exception to these general procedures around medical consent for foster youth involves emergency situations.[94] In an emergency where it is immediately necessary to provide medical care to the foster child to "prevent the imminent probability of death or substantial bodily harm to the child or others," consent is not required.[95]

There are specific sections of the Family Code which dictate the administration of psychotropic medication.[96] Section 266.0042 describes a detailed criteria for valid medical consent to the administration of psychotropic drugs, including the following: voluntary consent, the medical consenter receives information about the condition to be treated, the benefits, the consequences of not consenting, probable side effects, and generally acceptable alternatives.[97] Section 266.011 dictates how to monitor the use of psychotropic medication.[98] To monitor the use of psychotropic medication, the medical consenter must ensure that the child has been seen by the prescribing physician at least once every ninety days to appropriately monitor the side effects of the medication and determine whether the medication is helping the child and if continued use of the medication is appropriate.[99] Finally, Section 266.007 discusses judicial review of medical care. Judicial review requires the court to review a summary of the

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[91] TEX. FAM. CODE ANN. § 266.010(a) (West 2017).

[92] TEX. FAM. CODE ANN. § 266.010(b) (West 2017).

[93] TEX. FAM. CODE ANN. § 266.010(d) (West 2017).

[94] TEX. FAM. CODE ANN. § 266.009(a) (West 2017).

[95] *Id.*

[96] TEX. FAM. CODE ANN. § 266.0042 (West 2017); TEX. FAM. CODE ANN. § 266.011 (West 2017).

[97] TEX. FAM. CODE ANN. § 266.0042 (West 2017).

[98] TEX. FAM. CODE ANN. § 266.011 (West 2017).

[99] TEX. FAM. CODE ANN. § 266.011 (West 2017) (arguing that The child must be seen by the prescribing physician, physician assistant, or advanced practice nurse at least once every 90 days).

medical care provided to the foster child at each hearing.[100] For a child receiving psychotropic medication, there is a list of updates that must be included in the summary including any non-pharmacological interventions that have been provided to the child, dates of doctor's visits, "the degree to which the child" or medical consenter has complied with treatment, any side effects, any specific medical diagnoses, and other information required by department rule.[101] It appears that the judicial review process serves as an extra check to ensure that the child is not overmedicated or put in any medical danger.

B. Agency Oversight: What Happens if a Foster Child Falls Outside the Parameters?

The Parameters, discussed earlier, provide recommendations and best practices for the appropriate use of psychotropic medication for children served in the public health system, including foster care.[102] STAR Health is the health plan for most children in DFPS conservatorship.[103] STAR Health oversees automated reviews of pharmacy claims that identifies when children's medications appear to be outside the Parameters.[104] Additionally, STAR Health coordinators and medical consenters routinely conduct telephonic health screenings on children newly entering DFPS conservatorship or changing placements.[105] The Psychotropic Medication Utilization Review (PMUR) is the process STAR Health uses to screen children's psychotropic med-

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[100] TEX. FAM. CODE ANN. § 266.007 (West 2017) (arguing that at each hearing under chapter 263, or more frequently if ordered by the court, the court shall review a summary of the medical care provided to the foster child since the last hearing).

[101] TEX. FAM. CODE ANN. § 266.007 (West 2017).

[102] SUP. CT. OF TEX. PERMANENT JUD. COMM'N FOR CHILD., YOUTH, AND FAM., *supra* note 24, at 250.

[103] PSYCHOTROPIC MEDICATION UTILIZATION REVIEW (PMUR) PROCESS FOR STAR HEALTH MEMBERS: FAQ AND STAKEHOLDER MANUAL 2 (Superior Health Plan ed., 2023), https://www.dfps.texas.gov/Child_Protection/Medical_Services/documents/STAR_Health_PMUR_English.pdf [hereinafter PMUR].

[104] *Id.*

[105] *Id.*

ications and determine whether the treatment plan is outside of the Parameters.[106]

STAR Health does a PMUR after children have taken medication for at least sixty days and fall outside in the following categories: child under the age of four, a child taking four or more psychotropic medications, and antipsychotic medication prescribed without appropriate monitoring.[107] Being outside the Parameters means that a STAR Health psychiatrist must call the prescribing physician to review the child's case to make sure the medications are the best treatment for the child.[108] In the aftermath of a PMUR, sometimes medications are changed; other times, the child keeps taking the medications.[109] A PMUR can be triggered by STAR Health's automated reviews of pharmacy claims or by the telephonic health screenings. A PMUR can also happen when someone, such as a caregiver or medical consenter, has a concern and asks STAR Health for a review.[110] Finally, a PMUR is triggered when a court asks for a review.[111]

Physicians whose treatment plans consistently appear to be prescribed outside the Parameters despite the risks are referred to the Quality of Care (QOC) review process.[112] The physician's additional records are examined for pervasive patterns of over prescribing and certain qualifying cases may be referred to the Peer Review Committee for further action.[113] Any physicians showing a pattern of over or dangerous prescribing may be placed on corrective action and/or face disciplinary action.[114]

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[106] *Id.*

[107] *Id.*

[108] *Id.*

[109] *Id.*

[110] *Id.*

[111] *Id.*

[112] SUP. CT. OF TEX. PERMANENT JUD. COMM'N FOR CHILD., YOUTH, AND FAM., *supra* note 24, at 251.

[113] SUP. CT. OF TEX. PERMANENT JUD. COMM'N FOR CHILD., YOUTH, AND FAM., *supra* note 24, at 251.

[114] SUP. CT. OF TEX. PERMANENT JUD. COMM'N FOR CHILD., YOUTH, AND FAM., *supra* note 24, at 251.

The current regulatory system is a result of action taken by HHSC and DFPS in March of 2004 when they issued a report and recommendations.[115] These recommendations established the statewide clinical consultation and monitoring system described above as STAR Health's telephonic health screening program and the PMUR process.[116] Further, the 2004 recommendations improved the medical consenter training and expanded it to include general information on psychotropics, training on specific psychotropic medications, training in advocacy, and training on informed consent.[117] The Parameters were then created and published in February 2005 with routine updates throughout the years.[118] A DFPS report concluded that the general use of psychotropic drugs and polypharmacy in foster youth declined after releasing the Parameters.[119] The decline was "both in terms of the percentage of foster… youth receiving [psychotropic medications] and in the overall percentage of children and youth receiving medication regimens outside of the recommended criteria of the best practice parameters."[120] Texas law was altered to allow better regulation which in turn created a tangible impact on the overmedication of foster youth in DFPS conservatorship.[121] These improvements in the administration of psychotropic medications to children affirm the hope that change is possible. Although these changes represent hope for the current foster care system, *M.D. v. Ab-*

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[115] UPDATE ON THE USE OF PSYCHOTROPIC MEDICATIONS FOR CHILDREN IN TEXAS FOSTER CARE: STATE FISCAL YEARS 2002-2021 DATA REPORT 2 (Tex. Health and Hum. Servs. ed., 2022), https://www.hhs.texas.gov/sites/default/files/documents/update-psychotropic-medications-children-texas-foster-care-fy2002-2021.pdf; *see also* THE USE OF PSYCHOTROPIC MEDICATIONS FOR CHILDREN AND YOUTH IN THE TEXAS FOSTER CARE SYSTEM 1 (Tex. Dep't of Fam. and Protective Services Advisory Comm. on Psychotropic medications ed., 2004).

[116] UPDATE ON THE USE OF PSYCHOTROPIC MEDICATIONS FOR CHILDREN IN TEXAS FOSTER CARE: STATE FISCAL YEARS 2002-2021 DATA REPORT, *supra* note 115, at 16; *see also* THE USE OF PSYCHOTROPIC MEDICATIONS FOR CHILDREN AND YOUTH IN THE TEXAS FOSTER CARE SYSTEM, *supra* note 115, at 8.

[117] *The Use of Psychotropic Medications For Children and Youth In the Texas Foster Care System*, REPORT OF THE DFPS ADVISORY COMM. ON PSYCHOTROPIC MEDICATIONS (2004).

[118] UPDATE ON THE USE OF PSYCHOTROPIC MEDICATIONS FOR CHILDREN IN TEXAS FOSTER CARE: STATE FISCAL YEARS 2002-2021 DATA REPORT, *supra* note 115, at 2.

[119] *Id.*, at 2.

[120] *Id.*, at 3.

[121] *Id.*, at 3.

bott addresses many of the hardships faced by children in state custody and highlights the need for long-lasting reform efforts.

IV. M.D. V. ABBOTT

A. Procedural History

In 2015, a class action was brought against the State of Texas; the Plaintiffs were a class of children in long-term state custody known as the permanent managing conservatorship (PMC).[122] The Plaintiffs alleged that DFPS policies lead to "structural deficiencies" that effectively "place the class members at an unacceptable risk of harm in violation of the Fourteenth Amendment."[123] Ultimately, Senior District Court Judge Janis Jack, found that the Plaintiffs met the requisite burden of proof to prove their allegations against the state and qualify for injunctive relief.[124] Judge Jack granted the injunctive relief and required a court-appointed Special Masters to craft and oversee necessary reforms to the Texas foster care system and oversee their implementation.[125]

The State of Texas appealed to the Fifth Circuit in 2018, 2019, and again in 2020.[126] The Fifth Circuit repeatedly held that the district court had correctly determined that the State of Texas was at fault for subjecting the Plaintiffs to an undue risk of harm.[127] The Fifth Circuit majority held that DFPS was aware of the systemic failures riddling the agency's oversight practices and have failed to take reasonable steps toward a solution.[128] However, the Fifth Circuit also consistently held that Judge Jack's injunction was "significantly overbroad" and therefore, vacated and remanded accordingly.[129] The majority

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[122] M.D. v. Abbott, 152 F. Supp. 3d 684, 690 (S.D. Tex. 2015).

[123] *Id.* at 694 (internal quotations omitted).

[124] *Id.* at 822–23.

[125] *Id.* at 823.

[126] *See M. D. ex rel. Stukenberg v. Abbott*, 977 F.3d 479 (5th Cir. 2020); *see also* M.D. v. Abbott, 418 F. Supp. 3d 169, 171 (S.D. Tex. 2019); *see also* M.D. v. Abbott, 907 F.3d 237, 243 (5th Cir. 2018).

[127] *See Abbott*, 977 F.3d 479 (5th Cir. 2020); *see also Abbott*, 907 F.3d 237 (5th Cir. 2018).

[128] *Abbott*, 907 F.3d at 267–68.

[129] *Abbott*, 907 F.3d at 271.

further held that the current injunction, although reflective of best practices within the child-welfare community, goes beyond what is "minimally required" by the Fourteenth Amendment.[130]

B. The Aftermath of *M.D. v. Abbott*: Reports of the Monitors

To ensure the State's compliance with court orders, the Fifth Circuit mandated court Monitors to "assess and report on Defendants' compliance" with the court orders.[131] Routinely, the Monitors (together called the monitoring team) put together reports to update the courts on the status of the Texas child welfare system.[132] The monitoring team is composed of a wide range of professionals, including specialists in children's law, child welfare, data and policy analysis, social workers, and former foster youth.[133]

In the Monitor's first ever report, they tell the story of C.G.[134] After being released from a psychiatric hospital, C.G. was placed in an emergency shelter where she hanged herself in the bathroom.[135] C.G. spent seven long years in the Texas foster care system.[136] Her experience was characterized by increasing psychological distress and harm.[137] During 2019 and 2020, C.G. was admitted to a psychiatric facility three times, each time for suicidal tendencies and the risk of self-harm.[138] When she was discharged in March of 2020, the monitoring team found that C.G. was prescribed "at least three psychotropic medications for anxiety and depression."[139] C.G.'s treatment plan indicated that she was supposed to be on a safety plan and "monitored

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[130] *Abbott*, 907 F.3d at 272.

[131] First Court Monitors' Report 2020 at 10, M.D. v. Abbott, 152 F. Supp. 3d 684 (S.D. Tex. 2015) (No. 2:11-cv-00084) [hereinafter 2020 Monitors' Report].

[132] 2020 Monitors' Report, *supra* note 131, at 11.

[133] *M.D. v. Abbott Monitoring Team*, TEXAS APPLESEED, https://www.texasappleseed.org/md-vs-abbott-monitoring-team (last visited Nov 8, 2023).

[134] 2020 Monitors' Report, *supra* note 131, at 15.

[135] 2020 Monitors' Report, *supra* note 131, at 15.

[136] 2020 Monitors' Report, *supra* note 131, at 15.

[137] 2020 Monitors' Report, *supra* note 131, at 15.

[138] 2020 Monitors' Report, *supra* note 131, at 15.

[139] 2020 Monitors' Report, *supra* note 131, at 15.

by staff at all times."[140] This treatment plan was signed by the shelter staff, the shelter's clinical social worker, and C.G.[141] Despite these clear ministerial directions, the system failed C.G. as she remained dead on the bathroom floor for thirty minutes before anyone thought to check up on her.[142]

A safety plan for foster youth involves routine safety checks and vigilant and consistent monitoring to ensure the safety of children in state custody.[143] However, based on the monitoring team's report, it appears that C.G. only saw a psychiatrist one time (virtually) since her release from the psychiatric facility.[144] This seemingly goes against her treatment plan and required safety plan, which mandated that she be closely monitored at all times.[145] During their singular interaction, C.G.'s psychiatrist prescribed *three psychotropic medication changes*.[146] The monitoring team's evaluation reports that the psychiatrist used a form that appears to have "auto-populated a need for staff to observe [C.G.] every 15 minutes around the clock."[147] In other words, staff did not need to enter data into the form for the 15 minute check to be marked off; the form is automatically checked off every 15 minutes to depict that the mandatory check has taken place.[148] This is an unacceptable implementation of the treatment plan.

More importantly, the physician's actions go directly against the guidelines provided in the Parameters.[149] Aside from the numerous warnings about the potential for emergent suicidality when prescribing psychotropics, the Parameters state that for youth at risk of suicide, being prescribed psychotropic medication "should have a writ-

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[140] 2020 Monitors' Report, *supra* note 131, at 15.

[141] 2020 Monitors' Report, *supra* note 131, at 15.

[142] 2020 Monitors' Report, *supra* note 131, at 15.

[143] *Child Safety*, TEX. DEP'T OF FAM. & PROTECTIVE SERVS., https://www.dfps.texas.gov/Child_Protection/Child_Safety/default.asp (last visited Nov 8, 2023).

[144] 2020 Monitors' Report, *supra* note 131, at 15.

[145] 2020 Monitors' Report, *supra* note 131, at 15.

[146] 2020 Monitors' Report, *supra* note 131, at 15.

[147] 2020 Monitors' Report, *supra* note 131, at 356.

[148] 2020 Monitors' Report, *supra* note 131, at 356.

[149] PARAMETERS, *supra* note 33, at 7.

ten, collaborative safety plan that is regularly monitored."[150] Despite these specific best practices, it is not clear that any sort of safety plan was implemented for C.G.[151] The monitoring team's report further reveals that in March of 2020, after C.G.'s hospital release, a Child and Adolescent Needs and Strengths Assessment Evaluation indicated that C.G. was an "[o]verall suicide [r]isk" and required a same day safety plan.[152]

It seems the inappropriate administration of psychotropic medication to C.G. was not the sole cause of her suicide. However, it is also apparent that the three psychotropic medications she was prescribed, less than a month before her death, did not help her. Not only did her clinician fail her by not curating and implementing a safety plan for her, but so did the shelter staff and C.G.'s clinical social worker who signed off on her treatment plan, who then failed to comply with it.[153] Instead of implementing the treatment plan, the shelter staff and C.G.'s social worker failed to uphold or implement any sort of safety plan, despite it being painfully obvious how desperately C.G. needed one.[154] Children should not be prescribed psychotropic medications if they have suicidal ideations and cannot be closely monitored.[155]

Overall, this monitoring team's first report showed little evidence of medical treatment for children in state custody other than psychotropic drugs.[156] This is another violation of the best practices provided in the Parameters.[157] The Parameters plainly and explicitly assert that non-pharmacological, psychosocial treatments must be tried in remediating behavioral disturbances amongst foster youth.[158] There are numerous warnings in the Parameters discussing the ways

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[150] PARAMETERS, *supra* note 33, at 7.

[151] 2020 Monitor's Report, *supra* note 131, at 15.

[152] 2020 Monitor's Report, *supra* note 131, at 15.

[153] 2020 Monitor's Report, *supra* note 131, at 15.

[154] 2020 Monitors' Report, *supra* note 131, at 15.

[155] *See* PARAMETERS, *supra* note 33, at 7.

[156] 2020 Monitors' Report, *supra* note 131, at 62.

[157] PARAMETERS, *supra* note 33, at 3.

[158] PARAMETERS, *supra* note 33, at 4.

in which a child may be treated for their mental disorders that do not involve the use of psychotropic medications.[159] Despite this, the monitoring team's report illustrates the lack of any other treatments for mental and emotional disturbances besides psychotropics.[160]

C. The Most Recent Monitor's Reports: 2022-2023

A 2022 update from the court Monitors includes the feedback directly from foster youth who were interviewed for the report.[161] The report revealed that all children that were interviewed took psychotropic medications, yet only one child reported actually receiving the medication every day as prescribed.[162] One child reported that they had not received a psychotropic medication since they had run out, while another child had not received any medication for three days following their arrival at their placement.[163] Additionally, a third child had indicated that they had been prescribed medications prior to arriving at their placement, but was unable to get in contact with their caseworker to arrange an appointment with a psychiatrist to update their prescriptions.[164]

A 2023 update from the court Monitors documents numerous instances of children prescribed psychotropics in contravention of the Parameters, posing a serious risk to children's health and safety.[165] Of the 161 foster youth whose files were reviewed by the Monitors, 75 kids (47%) were prescribed four or more psychotropics.[166] Recall that a child prescribed four or more psychotropics falls outside the Pa-

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[159] PARAMETERS, *supra* note 33, at 3.

[160] 2020 Monitors' Report, *supra* note 131, at 62.

[161] The Court Monitors' Update Regarding Safety of Settings Housing Children Without Placement and Site Visits at 9, M.D. v. Abbott, 152 F. Supp. 3d 684 (S.D. Tex. 2015) (No. 2:11-cv-00084) [hereinafter 2022 Monitors' Report].

[162] *Id.*

[163] *Id.*

[164] *Id.*

[165] Update to the Ct. Regarding Site Visits Conducted between December 1, 2021, and December 31, 2022, and the Reopening of The Refuge for DSMT at 5, M.D. v. Abbott, 152 F. Supp. 3d 684 (S.D. Tex. 2015) (No. 2:11-CV-00084) [hereinafter 2023 Monitors' Report].

[166] 2023 Monitors' Report, *supra* note 165, at 7.

rameters, thus triggering a PMUR conducted by STAR Health.[167] Of the seventy-five children, a PMUR has only been completed for twenty-one children.[168] The PMUR for three children took place after the monitoring team's site visit.[169] The PMUR's for the three kids revealed that they were all "outside parameters" with "opportunities to reduce polypharmacy."[170] Despite this, the children's records showed that one child's medications had been reduced, the second child's medications remained the same, and the third child was taking the same medication with a new psychotropic added to his regimen.[171]

Ultimately, these incidents illustrate the routine failures of the Texas child welfare system in administering arrays of psychotropic medication to a population that is dependent on the State for their protection, with little to no regard for the State's own protocols for psychological diagnosis and medical oversight.[172]

V. RECOMMENDATIONS

A. Updating the State's Current Psychotropic Medication Utilization Review Process

As this comment highlights, the current regulatory system in place in the State of Texas fails to adequately protect foster youth from maladministered psychotropic medications. It appears that the current PMUR system is inefficient. As described in the 2023 update from the Court Monitors, 47% of the children whose files were reviewed needed a PMUR, yet only 13% had a PMUR take place.[173] The explanation provided for PMUR requests that do not result in an intervention is that PMUR's are intended to "retrospectively review stable medications."[174] Thus, when a child is in an unstable situation,

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[167] PARAMETERS, *supra* note 33, at 10.

[168] 2023 Monitors' Report, *supra* note 165, at 7.

[169] 2023 Monitors' Report, *supra* note 165, at 9.

[170] 2023 Monitors' Report, *supra* note 165, at 9.

[171] 2023 Monitors' Report, *supra* note 165, at 9.

[172] 2023 Monitors' Report, *supra* note 165, at 5–11.

[173] 2023 Monitor's Report, *supra* note 165, at 7.

[174] PMUR, *supra* note 103.

a PMUR is deemed "not appropriate at that time."[175] This means that if a child has had a significant medication change, the PMUR *must not* take place until sixty days have passed.[176]

The PMUR process can result in three different interventions.[177] The first option is a PMUR Initial Notification.[178] This option simply involves a behavioral health clinician who reviews the prescription and behavioral claims.[179] The clinician then notifies the prescriber that the child's regimen is outside the Parameter.[180] The second option is an Initial PMUR Report, which requires a pediatric psychiatrist to review the prescription and behavioral claims.[181] After, the psychiatrist makes a determination about the regimen and may offer suggestions to the prescriber.[182] Finally, a Repeat PMUR Report also requires a pediatric psychiatrist to review the prescription and behavioral claims.[183] After the psychiatrist makes a determination about the regimen, they may offer suggestions to the prescriber which could include a peer-to-peer call.[184] After a PMUR takes place, sometimes medications are changed; other times, the child keeps taking the medications.[185]

The current PMUR interventions do not involve any in-person visits with the child, or contact with the child and their medical consenter.[186] It is possible that behavioral claims or personal history of the child have been misinterpreted by their prescriber. There is no way for the individual conducting the PMUR to understand the child's perspective or to catch any misinterpretations if they have no

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[175] PMUR, *supra* note 103.

[176] PMUR, *supra* note 103.

[177] PMUR, *supra* note 103.

[178] PMUR, *supra* note 103.

[179] PMUR, *supra* note 103.

[180] PMUR, *supra* note 103.

[181] PMUR, *supra* note 103.

[182] PMUR, *supra* note 103.

[183] PMUR, *supra* note 103.

[184] PMUR, *supra* note 103.

[185] PMUR, *supra* note 103.

[186] PMUR, *supra* note 103.

contact with the child. Arguably, this is a change that could benefit foster youth who are prescribed numerous psychotropic medications. Moreover, this change falls within the best practices outlined in the Parameters which states that "[m]edication management should be collaborative[,]" by involving youth and caregivers to be part of the decisions surrounding treatment.[187]

In the most recent court hearing for *M.D. v. Abbott*, Jackie Juarez, an adult woman who spent seven years in the Texas foster care system, shared her experience being prescribed multiple psychotropic drugs.[188] She states that the medication would make her sleepy and cause her to throw up every night.[189] Juaraz is no longer taking any medication for mental health and explains that she can now better focus on sports, reading, and art.[190] Before leaving the stand, she testified, "No one ever questions the medications."[191] The implication suggests, had Juarez gone through a PMUR, her medications would not have changed, because in the end her prescriber deemed it necessary for her to be on psychotropic medication. Such a result can be avoided if the individual conducting the PMUR review takes the time to speak with the child. These children deserve to be heard by the professionals dictating their lives and prescribing them mind-altering medications.

Another aspect of the current PMUR process that can be adjusted involves a stronger push toward non-pharmacological interventions. As previously mentioned, the monitoring team's first report revealed a lack of non-pharmacological treatment for emotional disturbances amongst foster youth.[192] Where psychotropic medications are prescribed but other therapies are not provided and there is inadequate supervision of the medication, "healing and stabilization supporting

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[187] PARAMETERS, *supra* note 33, at 6.

[188] Avery Travis, *Psychotropic Drugs Take Center Stage in Texas Foster Care Fight*, AUSTIN (KXAN) (Dec. 5, 2023), https://www.kxan.com/investigations/psychotropic-drugs-take-center-stage-in-texas-foster-care-fight/.

[189] *Id.*

[190] *Id.*

[191] *Id.*

[192] 2020 Monitors' Report, *supra* note 131, at 62.

healthy growth will not occur."[193] For this reason, the individual conducting PMUR's should inquire into the non-pharmacological interventions that have taken place.

Another reason why the individual conducting the PMUR should emphasize alternative treatments is because it is one of the best practices outlined in the Parameters. The Parameters emphasize the importance of non-pharmacological, psychosocial treatments in remediating behavior amongst children in state custody.[194] Approaches such as cognitive behavioral therapy, group therapy, exercise, and nutrition are amongst the many ways to improve a child's mental health without medication.[195] Such approaches should be tried and recommended to prescribers before dunking the child in a pool of psychotropic medication with little efficacy data and largely unknown side effects.

B. A New, Proactive Approach to Psychotropic Medication Utilization Reviews

As C.G.'s story demonstrates, there is a need for a more proactive approach to medication utilization reviews.[196] Recall that C.G. met with a psychiatrist after being discharged from a psychiatric facility. In the single interaction C.G. had with this psychiatrist, she was prescribed four psychotropic medication changes.[197] Even though such drastic medication changes technically fall outside the Parameters, the current PMUR system would not allow for a review under these circumstances because C.G.'s medication regimen was not stable.[198]

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[193] JoAnne Solchany, *Psychotropic Medication and Children in Foster Care: Tips for Advocated and Judges*, AMERICAN BAR ASS'N (Feb. 1, 2012), https://www.americanbar.org/groups/public_interest/child_law/resources/child_law_practiceonline/child_law_practice/vol_31/Feb12/psychotropic_medicationandchildreninfostercaretipsforadvocatesan/.

[194] PARAMETERS, *supra* note 33.

[195] Gladys Castillano, *Natural Ways to Improve Mental Health in Children*, CHILD.'S MED. (Nov. 25, 2022), https://www.npcmc.com/2022/11/25/natural-ways-to-improve-mental-health-in-children/.

[196] *See* 2020 Monitors' Report, *supra* note 131, at 15.

[197] 2020 Monitors' Report, *supra* note 131, at 355–356.

[198] PARAMETERS, *supra* note 33, at 10; *see also* PMUR, *supra* note 103.

In order for a PMUR to be triggered, C.G. would have had to wait sixty days after being discharged from the hospital and/or sixty days after her medication change, whichever comes later.[199]

Unfortunately, C.G. took her own life within a month of being released from the hospital.[200] This is an example of where the current PMUR process is failing to adequately address the medical needs of foster youth. A proactive PMUR approach would flag such changes in a child's medication regimen for immediate review. This review would involve an in-person visit with the child to discuss their prior medical history, personal history, and their opinion as to whether the medication is needed. Of course, all children are not best suited to make such decisions on their own regarding their mental health treatment, but that does not mean they should not have a say at all. An in-person visit would also include a review of the child's current living situation as well as their medication logs. As previously noted, many medication logs in residential group homes are pre-filled out.[201] This form of negligent medical supervision is a violation that the reviewing team should look for, as it will hinder the youth's ability for healthy growth.[202] Moreover, as the Parameters establish, a child's mental health is significantly impacted by their environment.[203] Ensuring that the environment the child resides in is one that supports their growth and does not engage in negligent supervision should be an important aspect of a medication review.

Finally, the proactive medication review process should involve a team that includes a social worker, a child psychologist, and a child psychiatrist. This is another point derived from the Parameters which provides that, "optimal outcomes are achieved with a well-coordinated team-based care with members of different professions… each contributing their particular expertise to the treatment plan and follow-up."[204] Although such a team would be costly and require effort on the State's end to put together, this appears to be the

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[199] PMUR, *supra* note 103.

[200] 2020 Monitors' Report, *supra* note 131, at 354, 356.

[201] 2020 Monitors' Report, *supra* note 131, at 342–343.

[202] Solchany, *supra* note 193.

[203] PARAMETERS, *supra* note 33, at 3–4; *see also* PMUR, *supra* note 103.

[204] PARAMETERS, *supra* note 33, at 4.

best way to provide a holistic review for the child's medication regimen. It is well-established that foster youth are victims of neglect and abuse.[205] This vulnerable population is relying on the State to take care of them when their own family is unable to do so.[206] It is imperative to treat them as the vulnerable, dynamic, and traumatized children that they are with the utmost care, love, and respect.

Thinking back to C.G.'s story, a proactive medication review such as the one outlined above could have saved her life. A proactive medication review would have involved a professional visiting her placement, speaking with her about her experience, and asking her what she needs. C.G. presented numerous warning signs to the point where she was to be observed by staff every 15 minutes.[207] Aside from the fact that the staff failed to check in on her as often as required in her safety plan, C.G. was obviously at high risk and in need of special attention. The drastic changes to her medication regimen, the numerous warnings from prescribers, and the three psychiatric facility visits should have set off alarm bells. It is possible that a proactive medication review would have flagged the inappropriate implementation of her treatment plan by the staff at her placement. It is possible that the proactive medication review would have caught onto the negative impact the psychotropic medications had on C.G.'s mental health. It is possible that the proactive medication review could have saved C.G's life.

Every child who falls outside the Parameters should not have to wait sixty days before their files are reviewed for maladministration. The current system would benefit from an additional step in the review process. Even if the PMUR process is to remain the same, there should be an additional review for children who are high risk, suffering from severe mental illnesses, and/or children under the age of ten taking psychotropic medication. Moreover, any "as needed" prescriptions should immediately be flagged and reviewed to ensure that the medication is not being used as a chemical restraint. So much

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[205] PARAMETERS, *supra* note 33, at 4.

[206] *Foster Care*, TEX. DEP'T OF FAM. & PROTECTIVE SERVS., https://www.dfps.texas.gov/Child_Protection/Foster_Care/default.asp (last visited Sept. 23, 2023).

[207] 2020 Monitors' Report, *supra* note 131, at 354–356.

can happen in sixty days and as C.G's story demonstrates, not every child can afford to wait that long.

C. Updating The Parameters as It Pertains to Children Between the Ages Of Thirteen to Seventeen

Finally, another recommendation that can help positively impact the livelihood of foster youth in terms of their medical treatment involves an additional section being added to the Parameters. Created in 2004, the Parameters is a toolkit that highlights best practices and includes a list of medications and recommended dosages.[208] Since the creation of the Parameters, the overall percentage of foster children receiving psychotropic medication went down from 29.5% of all foster youth in 2004 to 17.9% in 2019.[209] From a bird's eye view, this is a significant decrease and represents the positive impact of the Parameters.

Figure 1 indicates that foster youth between the ages of ten to eighteen are significantly more likely to be prescribed psychotropic medication compared to any other age group.[210] Figure 2 further illustrates the percentage of foster youth taking psychotropic medication from 2002 and 2019, categorized by age group.[211] Since the release of the 2004 Parameters, each age group has had a significant reduction in the percentage of youth taking psychotropic drug use between 2002 and 2019 *except* the age group of thirteen to seventeen year olds.[212] Foster youth between the ages of thirteen and seventeen went from 47.5% of children taking medications in 2002 to 43.5% in 2019.[213] In comparison to the other age groups, thirteen to seventeen

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[208] PARAMETERS, *supra* note 33, at 3.

[209] 2023 Monitors' Report, *supra* note 165, at 4; *see also* UPDATE ON THE USE OF PSYCHOTROPIC MEDICATIONS FOR CHILDREN IN TEXAS FOSTER CARE: STATE FISCAL YEARS 2002-2019 DATA REPORT 4, (Tex. Health and Human Serv. Comm'n, ed., 2021), https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2021/psychotropic-meds-tx-foster-care-fy2002-2019.pdf.

[210] Rachel Keefe, *supra* note 62.

[211] 2023 Monitors' Report, *supra* note 165, at 4.

[212] 2023 Monitors' Report, *supra* note 165, at 4.

[213] 2023 Monitors' Report, *supra* note 165, at 4.

year olds experienced the least significant decrease in psychotropic medication use.[214]

[214] 2023 Monitors' Report, *supra* note 165, at 4.

Figure 1: Percent of Children on Psychotropic Medication by Age Group [215]

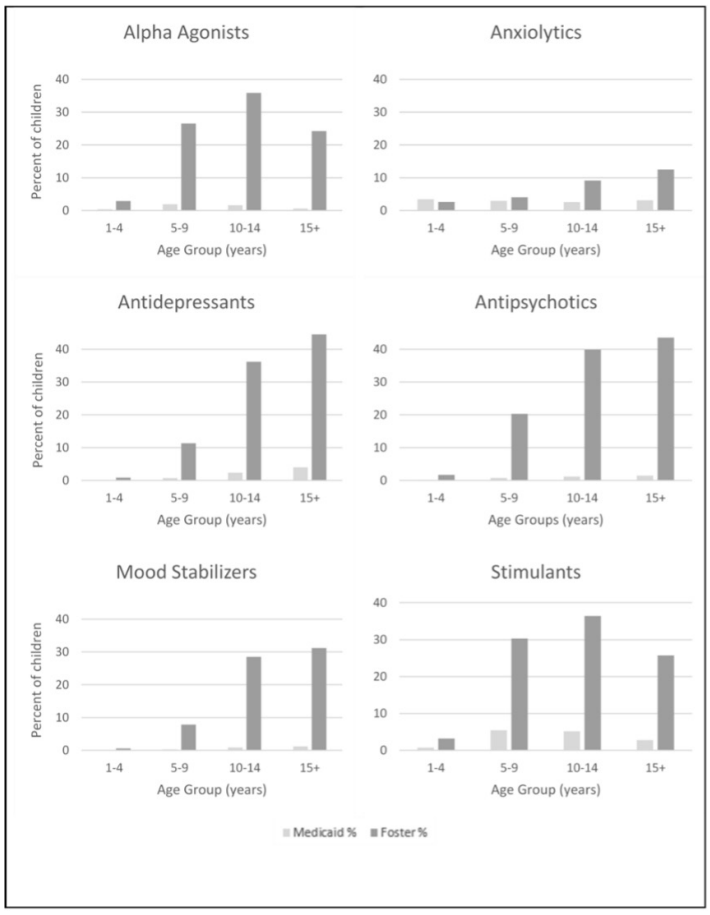

Figure 2: Children in the Foster Care System Taking Psychotropic Medication Sixty or More Days in the Years, 2002 and 2019 [216]

Age Group	0-3		4-5		6-12		13-17		Total	
	2002	2019	2002	2019	2002	2019	2002	2019	2002	2019
Total Foster Children	8,639	20,150	2,678	6,262	8,652	15,544	7,377	8,815	27,346	50,771
Children Taking Meds 60+ days in Year	247	286	527	663	3,795	4,289	3,503	3,834	8,072	9,072
% Taking meds 60+ days in Year	2.9%	1.4%	19.7%	10.6%	43.9%	27.6%	47.5%	43.5%	29.5%	17.9%

[215] Rachel Keefe, *supra* note 62.

[216] 2023 Monitors' Report, *supra* note 165, at 4.

To address the best way to treat mental health amongst foster youth between the ages of thirteen and seventeen, the discussion must begin with an explanation as to why psychotropic medications should not be a prescribing physician's first treatment plan. Firstly, it is important to note that hormones play a crucial role in influencing various aspects of a teenager's mental health.[217] During a child's teenage years, their body undergoes intense hormonal fluctuation that affect their mood, behaviors, and general health.[218] Such hormonal changes can lead to teens experiencing "mood disorders, intense feelings, and heightened stress sensitivity."[219] Such changes can make it difficult for the prescriber to differentiate between an underlying mental illness and hormonal changes, thus creating a high risk for overmedication.[220]

Another issue that is worth discussing is that many teens nowadays face even more challenges than before.[221] With the recent COVID-19 pandemic and related familial and financial losses, today's teens have faced unprecedented times.[222] Moreover, as political turmoil ravages the country, these teens have "experienced or witnessed racial- and identity-based discrimination, gun violence, political unrest, natural disasters, and climate change."[223] Even without the additional pressures of an unstable home environment and the stressors

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[217] *The Effects Of Teenage Hormones On Mental Health*, PARADIGM TREATMENT CTR., https://paradigmtreatment.com/who-we-treat/teens/hormones/ (last visited Jan. 31, 2024).

[218] *Id.*

[219] *Id.*

[220] J. Philip Reimherr & Jon M. McClellan, *Diagnostic Challenges in Children and Adolescents with Psychotic Disorders*, 65 J. CLIN. PSYCHIATRY 4439 (2004) ("During the early phases of psychotic illnesses, it may be difficult to distinguish the developing psychotic symptoms from other more common symptoms of childhood psychopathology… Clinicians unfamiliar with normal child developmental processes may misconstrue common mental and emotional states as representing psychoses. Young children may demonstrate fantasy beliefs and play that are potentially misinterpreted as delusional when judged by adult standards").

[221] *Teens Are Talking About Mental Health*, NIH MEDLINEPLUS MAGAZINE, https://magazine.medlineplus.gov/article/teens-are-talking-about-mental-health (last visited Jan 31, 2024).

[222] *Id.*

[223] *Id.*

of being in state custody, the average teen is experiencing significant mental, hormonal, and physical changes.[224]

Keeping in mind the hormonal changes and the individual experiences of teenagers, plus the additional trauma of being separated from their family unit and being put into state custody, teenage foster youth have many reasons to act out or struggle with mood swings and emotional regulation.[225] Because these struggles are natural to their lived experiences, teenagers do not need copious amounts of psychotropic medication (if any at all).[226] This is not to say that teenage foster youth do not experience severe mental health issues from mood disorders to psychosis.[227] This is to point out that if the child welfare system focuses on healing some of the underlying issues and root causes of a child's mood swings and irrational behavior, the system may be able to adequately address the mental health of foster youth without psychotropic medication.[228] As a reminder, psychotropic medication has not been rigorously tested amongst children the way it has been for adults.[229] Therefore, it only seems appropriate to limit the number of off-label prescriptions to foster youth when the consequences and possible health repercussions are unknown.[230]

Because there is limited data proving the efficacy and long-term effects of psychotropic medication use amongst adolescence, and because there are several other treatments available for psychiatric dis-

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[224] *Id.*

[225] Delphine West et al., *Behavior Problems In Foster Care, Systematic Review Of Associated Factor*, 155 CHILD. & YOUTH SERVS. REV. 1 (2023).

[226] *See* Shaheen E. Lakhan & Gareth E. Hagger-Johnson, *The Impact of Prescribed Psychotropics on Youth*, 3 CLIN. PRACT. EPIDEMIOL MENT. HEALTH 21 (2007).

[227] Kimber E. Strawbridge, *The Children Are Crying: The Need for Change in Florida's Management of Psychotropic Medication to Foster Children*, 15 U.C. DAVIS J. JUV. L. & POL'Y 247 (2011).

[228] Lyle Murphy, *The Alarming Trend of Psychiatric Polypharmacy on Anxious Teens*, ALT. TO MEDS. CTR., https://www.alternativetomeds.com/blog/polypharmacy-anxious-teens/ (last updated Sept. 2023) ("Using more natural healing methods can enable teens to manage mental health by keeping the body and mind in better shape. All the bodily systems work together, and a holistic approach can ensure all the potential causes of mental health symptoms are addressed, rather than relying on medications to treat their effects").

[229] Lakhan & Hagger-Johnson, *supra* note 226 ("Many psychotropics prescribed to children are unlicensed or off-label, meaning that they are used for purposes other than for which they are officially approved. However, little is known about their long-term impact").

[230] Lakhan & Hagger-Johnson, *supra* note 226.

orders in adolescents, the Texas child welfare system should put a greater emphasis on non-pharmacological treatment plans.[231] One way to implement this change is through additional guidelines in the Parameters. Since the Parameters has proven to be largely successful in decreasing the overall percentage of foster youth taking psychotropic medications,[232] it is a seemingly good avenue to discourage physicians from prescribing psychotropic medications to teenagers and encouraging the use of non-pharmacological interventions instead. The Parameters can highlight techniques prescribers can use to avoid over-medicalization and prioritize non-pharmacological, psychosocial treatment options specifically for foster youth between the ages of thirteen to seventeen.

A section in the Parameters dedicated to teenagers could include a discussion of alternative treatment plans for foster youth. Non-pharmacological treatments include cognitive behavioral therapy, counseling, creative therapies, exercise, mindfulness, mentoring programs, play therapy, psychoeducation, and more.[233] Further, this section would outline the difficulties in treating foster youth within this age group and how to best deal with such difficulties. This section might also discuss pertinent mental illnesses in this age group and how to treat them best with and without psychotropic medication.[234]

Additionally, because this is the age group with the greatest ability to think for themselves,[235] there should be guidance on how to take care of them. This could also include literature on warning signs to look for, questions to ask, and the importance of asking for the youth's input on their own treatment plan. It is not enough to prescribe these children with a list of medications and expect them to be

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[231] Brenner et al., *supra* note 67, at 666–67; *see also* Zito et al., *supra* note 69, at 7, 10.

[232] 2023 Monitors' Report, *supra* note 165, at 4.

[233] *Children's Mental Health Treatment and Support*, ASS'N FOR CHILD.'S MENTAL HEALTH, https://www.acmh-mi.org/get-information/childrens-mental-health-101/treatments-supports/ (last visited Jan 17, 2024).

[234] Jai K. Das et al., *Interventions for Adolescent Mental Health: An Overview of Systematic Reviews*, 59 J. ADOLESC. HEALTH, S49, S50, S58 (2016), https://doi.org/10.1016/j.jadohealth.2016.06.020; *see also* Vincent Hede & Cédric Devillé, *Treating Psychiatric Symptoms And Disorders With Non-Psychotropic Medications*, 21 DIALOGUES CLIN. NEUROSCI. 193 (2019), https://doi.org/10.31887/DCNS.2019.21.2/vhede.

[235] TEX. FAM. CODE ANN. § 107.003(a)(3)(G)(b)(3) (West 2017).

fine. There should be a dialogue between the treating physician and the child regarding the child's ideas on what treatment plan might be best for them. Children in state custody deserve to have a say in the medications and treatment being prescribed to them. At the very least, the child should understand what each medication is supposed to do and what it is for. This will help in future appointments because the child will better be able to explain how effective the medications are, and if the medications are doing what they are supposed to be doing.

Because the Parameters have been effective in decreasing the percentage of foster youth taking psychotropic medication,[236] it seems plausible that a section in the Parameters dedicated to teenagers could decrease the percentage of teenage foster youth taking psychotropic medication. Moreover, a section like this could change the way prescribers conduct their appointments with foster youth. In turn, this could change the youth's willingness to participate in treatment programs and strengthen their faith in their prescribing physician.

VI. CONCLUSION

The Texas foster care system is plagued with abuse, neglect, and medical maltreatment. One of the many reforms that could positively impact the current child welfare system involves increased regulation and better administration of psychotropic medications. Psychotropic medication includes antidepressants, antipsychotics, and other drugs that are used to treat mental, emotional, and behavioral disorders.[237] These medications are not a cure and instead work to manage symptoms of mental illnesses.[238] Importantly, side effects vary in severity from minor inconveniences to more serious complications.[239]

The Texas Parameters serves as one of the many tools for physicians treating mental illnesses amongst foster youth. The Parameters create regulation and describe the procedure of administering psy-

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[236] 2023 Monitors' Report, *supra* note 165, at 4.

[237] *See* TEX. FAM. CODE ANN. § 266.001 (7) (West 2017).

[238] Smitha Bhandari, *supra* note 20.

[239] *List of Psychotropic Medications and Side Effects*, *supra* note 28.

chotropic medication to children in state custody.[240] However, recent data from court-ordered reports illustrate the dire need for reform regarding the enforcement of regulation procedures detailing the administration of psychotropic medication to foster youth.[241]

An essential part of this discussion is the lack of FDA approval and oversight of psychotropic medication amongst children. It is well-established that many psychotropic medications do not have FDA approved labeling for use in children.[242] Psychotropics do not have FDA approved labeling for use in children because the medication being approved by the FDA is based on research on adults, not children.[243] Moreover, the FDA does not regulate health provider practices or how medication is administered.[244] The lack of FDA oversight gives rise to the use of medication for "off-label" purposes.[245] Prescribing psychotropic medication for off-label use is a regular practice that is especially relevant in child psychiatry due to the lack of FDA registration trials involving adolescents.[246]

Additionally, there are many difficulties in diagnosing mental health disorders amongst foster youth. This difficulty is emphasized as there are no biomarkers to assist with the diagnosis of medical disorders, making it harder for prescribing physicians to accurately diagnose a child.[247] The challenges in diagnosing, coupled with the lack of FDA approval, and minimal research on the risks psychotropics have on adolescents, the overall best practice is to not prescribe children with psychotropic medication except as a last resort.[248]

Different studies have also confirmed that children in foster care are significantly more likely to be prescribed psychotropic medica-

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[240] PARAMETERS, *supra* note 33, at 3.

[241] *See* Garret, *supra* note 35.

[242] PARAMETERS, *supra* note 33, at 5.

[243] PARAMETERS, *supra* note 33, at 5.

[244] PARAMETERS, *supra* note 33, at 5.

[245] PARAMETERS, *supra* note 33, at 5.

[246] *See* PARAMETERS, *supra* note 33, at 5; *see also* U.S. FOOD & DRUG ADMINISTRATION, *supra* note 42.

[247] PARAMETERS, *supra* note 33, at 4.

[248] *See* PARAMETERS, *supra* note 33, at 3.

tion than their non-foster peers.[249] The studies discussed in this comment are important because they illustrate how psychotropic medication is often prescribed to youth in state custody at alarming rates, thus emphasizing the urgent need for reform.

When a child is in state custody, they have a designated medical consenter who is given the authority to consent to medical care for the child. Each medical consenter must complete a department approved training which emphasizes the principles of informed consent and non-pharmacological interventions.[250] These procedures create uniformity and focus on the importance of the youth's assent to their individual treatment regimen.

Should a child's treatment regimen fall outside the guidelines outlined in the Parameters, a PMUR process will take place. Being outside Parameters means that a STAR Health psychiatrist must review the child's case to make sure the medications are the best treatment for the child.[251] This process serves to ensure that the treatment plan approved by the medical consenter is the appropriate regimen for the child. The state-mandated regulatory procedures involving a medical consenter and the PMUR process work together to provide children in state custody with holistic treatment plans that best serve their individual needs.

Despite the State's best efforts, the challenges imposed onto foster youth at the State's direction came to light in 2015 when *M.D. v. Abbott* was presented before the Fifth Circuit. In reviewing the facts, Judge Jack found that Texas places foster youth at an unacceptable risk of harm in violation of the Fourteenth Amendment.[252] To ensure the State's compliance with court orders, the Fifth Circuit mandated court Monitors to "assess and report on Defendants' compliance" with the court orders.[253] The court reports revealed horrifying stories of foster youth and numerous *violations* of the clear guidelines out-

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[249] *See Youth in Foster Care Compared with Other Medicaid Enrollees, supra* note 60, at 154.

[250] *See* TEX. FAM. CODE ANN. § 266.004 (h), (h1)(WEST 2017).

[251] *See* PMUR, *supra* note 103.

[252] M.D. v. Abbott, 152 F. Supp. 3d 684, 828 (S.D. Tex. 2015).

[253] 2020 Monitors' Report, *supra* note 131, at 10.

lined in the Parameters.[254] The court Monitors have released updated reports every year.[255] The reports illustrate the routine failures of the Texas child welfare system in administering various psychotropic medication to a population that is dependent on the State for their protection, with little to no regard to the State's own protocols for psychological diagnosis and medical oversight.[256]

Although there are many changes to be made, the State's regulation of psychotropic medication prescribed to foster youth is a good starting point. The current PMUR system is inefficient and should be updated to cater to the needs of children in state custody more adequately. One important change to the current PMUR process is the addition of in-person visits when conducting reviews of a child's treatment plan. Another suggestion is to adjust the PMUR process to put forward suggestions towards non-pharmacological treatment options for emotional disturbances instead of psychotropic prescriptions.

Another way to reform the current system would be to take a more proactive approach to the medication utilization reviews. A proactive PMUR approach would flag major changes in a child's medication regimen for immediate review rather than forcing a child to wait sixty days for their medication regimen to be stable. This review would involve an in-person visit with the child to discuss their prior medical history, personal history, and their opinion as to whether the medication is needed. Finally, the proactive medication review process should involve a team that includes a social worker, a child psychologist, and a child psychiatrist.

The final recommendation is to create an additional section to include in the Parameters. The new section would pertain to children between the ages of thirteen and seventeen. This age group has proven to be particularly vulnerable to polypharmacy.[257] Because this age group experiences hormonal changes, peer pressure, and bodily

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[254] *See* 2020 Monitors' Report, *supra* note 131, at 12–13; *see* 2022 Monitors' Report, *supra* note 161, at 2–6; *see* 2023 Monitors' Report, *supra* note 165, at 5–11.

[255] *See e.g.*, 2020 Monitors' Report, *supra* note 131, at 1.

[256] *See* 2020 Monitors' Report, *supra* note 131, at 13, 21, 343; *see* 2022 Monitors' Report, *supra* note 161, at 15, 35, 38; *see* 2023 Monitors' Report, *supra* note 165, at 5–11.

[257] *See* 2023 Monitors' Report, supra note 165, at 4.

changes, specific guidance on how to best treat mental illness within this age group may be especially useful for prescribing physicians who deem psychotropic medication as the only viable solution. Such a section could emphasize non-pharmacological interventions and focus on different ways to treat this age group.

Overall, the Texas foster care system has a long way to go. As more and more children enter the system, there is room for more and more reform. As illustrated by the stories in *Abbott* and the subsequent court-ordered reports from the Monitors, state-sponsored overmedication of foster youth is just the beginning when analyzing the challenges faces by youth in state custody.[258] Although this paper provides valuable insights into the complexities of overmedicated foster youth, there is much left unexplored.

Ultimately, addressing the overmedication of foster youth is an imperative task that demands collective attention and concerted action. The journey toward reforming the child welfare system and combatting the overmedication of foster youth requires sustained commitment, advocacy, and collaboration across all levels of society. By prioritizing the best interests of children and upholding their rights to receive safe, effective, and compassionate care, society can strive towards a future where every foster child has the opportunity to thrive and reach their full potential. "*[T]hese children have for too long been forgotten. Their stories deserved to be told.*"[259]

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[258] *See* M.D. v. Abbott, 152 F. Supp. 3d 684, 722 (S.D. Tex. 2015); *see e.g.*, 2023 Monitors' Report, *supra* note 165, at 4-11.

[259] *M.D.*, 152 F. Supp. at 718.